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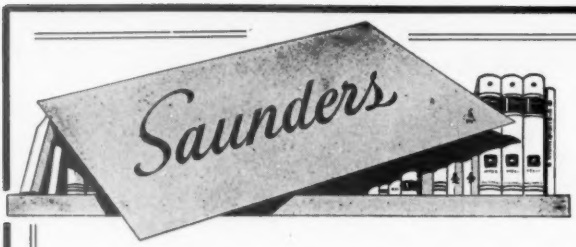

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*Roberts, L. J., Blair, R., Greider, M. *Results of providing a liberally adequate diet to children in an institution.* J. Pediatrics 27:393:410:418 (Nov.) 1945

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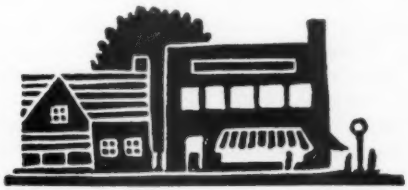
Interaction Is a Two-Way Process

AT ONE OF THE regional conferences a young NOPHN member said, "I've enjoyed this meeting more than any professional conference I've ever attended. I've tried to think why this is so and have come to the conclusion that it is because all the discussion is so down to earth, so practical." Since it was the aim of the NOPHN staff and the local planning committees to arrange programs that would offer some help, some guidance, some inspiration to all who attended, the above comment is high commendation.

The war interrupted the schedule of regular regional meetings and the many new pressures and ever-present budgetary problems have limited the number of meetings held in the last few years. To the national office this has been a serious handicap. If members receive assistance and direction from meeting with their fellow workers from other localities, think how helpful the same experience is to the national staff whose ears must always be tuned to the grassroots if they are truly to answer the needs of the countrywide membership.

Yes, we are glad the young member, who we hope spoke for many of the conference participants, found the discussions down to earth. Consultants in ivory towers are soon isolated and out of touch with reality. Meetings such as those held in April and May in Omaha, Providence, Portland, and New Orleans bring us close together not only physically but also in approaching and working through problems. The opportunity to meet face to face with hundreds of members is an experience valued by the NOPHN staff. From this learning through sharing come a more direct realization of local problems and conditions, a deeper appreciation of the kind of help needed, and most of all, a rededication to the overall goal of helping communities to establish, improve and expand their public health nursing services.



Research in Nursing

The research investigator must have curiosity and imagination. She must be willing to follow blind leads, and above all, she must have intellectual integrity.

MARION FERGUSON, R.N.

IS ONE PUBLIC health nurse needed for every 2,500 people? Should every local health agency be expected to make field experience available for students? In what ways can nurses function most effectively in meeting the legal responsibilities of the health department?

These and similar problems arise daily as the nursing profession seeks better ways to meet its responsibility to the patient and to the community. It is easy enough to raise such questions. Finding answers is a real feat, but not an impossible one. Essentially this becomes a matter of research.

But what is research? An unnamed source has defined research as "dragging data out of an inaccessible place, tabulating them, and then filing them in an equally inaccessible place." Another has said, "research is not everything someone has thought about twice." The dictionary defines research as "diligent protracted investigation; studious inquiry. Specifically in science, a systematic investigation of some phenomenon or series of phenomena by the experimental method."

Pauline D. Young, in "Scientific Social Surveys and Research," describes social research "as the systematic method of discovering new facts or verifying old facts, their sequences, interrelationships, causal explanations, and the natural laws which govern them. The primary goal of research—immediate or distant—is to understand social life and thereby gain a greater measure of control over social behavior."[1]

Lent D. Upson states, "True research in the social fields is to collect facts about a specific problem, to measure them, to compare them with other facts or generally accepted truths, and to draw conclusions."[2]

There are various modifications of these definitions, in accordance with the interpretation of the individual, but the essential qualities of investigation, experimentation, evaluation, and conclusion are common to all.

One is constantly confronted with problem solving in routine living. This involves recognition of a problem, consideration of the factors which will guide thinking on the problem, and then the conclusion reached. For example, everyone, particularly a woman, is faced daily with the problem of what to wear. She will consider the weather, the people she expects to see, the places she will be, the activity she will perform, the time of her return home, and then will make her decision as to apparel in light of all these factors.

Scientific method

This same process is necessary for solving problems in any area. As it becomes more formalized it is referred to as the scientific method. Good, Barr, and Scates, in their

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book on research, outline six distinguishing features of the scientific method " . . . (1) its appeal to facts (2) its application of the method of analysis (3) its use of hypotheses (4) its freedom from emotional bias (5) its use of objective measurement and (6) its use of quantitative methods in the treatment of data."[3]

This procedure is used in service studies and research also to find answers to problems. Service studies and research have many attributes in common. Basically the difference is largely a matter of scope, of intensity, and of size of the project. The service study has immediate and restricted application and involves use of data that apply only to a particular situation. It has, in common with research, a systematic planning of procedure and a careful checking of results at each step. The service study or survey may serve its purpose when it removes the difficulty encountered or it may serve as a segment of a research project. Research, on the other hand, undertakes the definition of basic general principles that can be applied universally. It usually involves a large number of cases and long time intervals.

Research in physical and social sciences

Research is thought of most often in connection with the physical sciences. It is equally useful in the social sciences although the complexity of society has been somewhat of a deterrent to its use. The ways to approach any complex problem are (1) to break it down into its simplest components and to examine each part and (2) to develop technics for handling an increasing number of variables. A beginning has been made on each of these approaches.

Physical science, too, was complex when it was at a stage of development comparable to the present status of knowledge of fundamental principles of social science. Through the years increasingly accurate measuring instruments and recording devices have been developed for use in the physical sciences. These have made it possible for workers to achieve a degree of objectivity in reporting their work and have enabled other workers to verify the findings so reported. At one time heat and cold could be reported only as subjective sensations. Now they can be reported in terms of a scale on a thermometer so that anyone who can read a thermometer can verify the reading of another. Such concepts are developed as a result of extensive, reliable records kept over a long period of time.

In the physical sciences it is much easier to set up true experimental conditions in which the situation is under the control of the investigator. In social sciences the investigator is sometimes hampered by the fact that he is dealing with human society and the human being, either singly or in groups. Such a situation is unpredictable and hard to control. In addition, because he himself is a member of the group the investigator may be influenced in his observations. Despite the necessity for establishing some sort of controls in any research situation it is admittedly difficult to set up such controls in most social studies. Furthermore, individuals or groups may not behave in the same manner under study conditions as similar individuals or groups not under observation. Precise laboratory methods cannot be carried out in social research and the wide range of variables makes delimitation of a study difficult. There is no well charted path for the researcher in the social sciences.

Qualities of the researcher

A certain amount of glamour is connected with the word research by some people. Disillusionment often comes to the beginning investigator when he finds that glamour is a very small part of the job, that most of it is sheer monotony and hard labor, that discoveries of scientific laws are few and far between and result only from lengthy and exhaustive work and discipline. The endless taking of measurements, the recording of repeated observations, the interviewing of many people, the editing and coding of numerous schedules, the limitless calculations for tables, form the bulk of the work on any research investigation.

The research investigator must have curiosity, imagination, persistency, and a healthy

skepticism about the obvious. He must be willing to follow blind leads and to be alert to subconscious flashes which may bridge the gap between the "hunch" and the real result. Above all, he needs intellectual integrity because that is basic to all research.

Objectivity and bias

Objectivity is usually listed as the prime requisite for anyone who is going to do research. Volumes have been written about the subject. Is it possible to be entirely objective? All knowledge comes to the individual through his senses so that what is perceived differs from person to person. One is influenced by his physiological condition, by his physical environment, by his training and experience, by the mores of his culture. The neuromuscular alignment that determines what shall be perceived and how it shall be interpreted is referred to as "bias."

Bias is a word that has sometimes been in disrepute because of the connotation of prejudice. In the scientific sense it simply means the particular slant of the individual. Each individual has his own characteristic bias. This differs from person to person. If one is realistic in attempting to achieve objectivity he is aware of his own bias and then chooses his area of investigation and his method of procedure in view of this bias.

One must be alert for bias in agencies and groups as well as in himself. Too often research is sponsored because the agency expects to prove that what it is doing is good or desirable rather than to learn the facts. Vested interests have influenced research findings and have even caused their suppression, depending upon whether the findings were to their advantage or disadvantage. Many organizations and professions whose purposes are lofty and commendable will not face facts which present a real or implied threat to their prestige or program.

Planning a research project

Before undertaking any research project one should consider certain factors. Is basic information in usable form available or can it be obtained? To what extent is the satisfactory completion of the study dependent upon factors outside the control of the investigator? The more this is so, the more precarious is the undertaking. Is there sufficient time to do the study? What will it cost? What arrangements for personnel, including clerical help, need be made? Are supplies and equipment adequate for tabulation and analysis? Will the report be made available to those who can utilize its findings?

Methods used in carrying on research vary considerably and the one selected in any particular instance will depend upon the problem. The historical, the case, the experimental, the investigative method—each has its place in research. Any study of the development of public health nursing in this country would utilize the historical method. Clinical medicine depends, to a great degree, upon the case method because conclusions must often be arrived at from limited material. The experimental method is much easier in the physical sciences than in the social since man is a bit difficult to keep in a controlled situation, and the factor of the control, in and of itself, has to be reckoned with in interpretation of findings. Some technics have been developed whereby the experimental method, in a limited form, can be used in the social sciences. The investigative method is the one that is used most frequently and the one that seems to yield the most promising results at our present stage of development of technics for studying society.

When any research project is being considered one of the first steps is to determine its purpose. This can be done most easily by asking a series of questions. These questions should serve to define the objective, delimit the problem, and guide the plan for and the conduct of the investigation. The problem should be defined in specific terms. The plan for the study should cover the kinds of data needed, the sources, and the methods to be used in getting them. Next comes a review of existing material on the subject. Perhaps the problem has been answered already or certain parts of the investigation have been done so that one can proceed from there. The formulation and testing of hypotheses or assumptions on the subject

serve to limit the area of investigation and offer a means of determining the relationship among facts. The collection of material is followed by its classification, analysis, and finally interpretation, recommendations, and prediction.

The preparation of a timetable setting a deadline for the completion of each step of the project is invaluable. The time allowed for analysis and interpretation of the data should be at least as much as for their collection. In planning, the time necessary for writing the report is often overlooked.

Documentation

The investigation should be carefully documented and the procedure used outlined so that another worker could repeat the experiment under conditions similar to those originally employed. It is recognized that the findings of any experiment, in either physical or social science, are as of a given time and place and under given conditions. In records of repeated observations under conditions as similar as possible a common thread begins to appear. Eventually this forms the basis for the formulation of a scientific theory or law which is "true" as of the stage of man's knowledge at that time. The real scientist is constantly on the alert for negative findings, for even the single observation that does not conform, although it may invalidate all of his work to that point. Such is the price of progress in scientific discovery.

Research in nursing

The nursing profession has been aware of the value of research as a way of problem solving for a long time. Probably no other professional group has been studied, analyzed, and evaluated more. Up to now most of these studies have been done by persons whose primary interest and training were in research. Many problems in any field can be solved more expeditiously by such a person than by a worker in the area under investigation. Other problems can be studied best by a person in the particular profession. Too few groups have individuals skilled both in the particular profession and the field of research.

Nurses by virtue of their preparation are skilled observers so they have one of the essential attributes for research. The make-up of the individual determines whether he can do research because, as in other areas, a certain point of view, a certain state of mind, is basic.

Another way to do research is through the team concept where representatives of two or more fields contribute the skills of their disciplines to the solution of mutual problems. This necessitates a healthy respect on the part of each participant for the resources, the skills, and the know-how of the others. It also involves an appreciation by every worker of the importance and the value of each part of the investigation, no matter how apparently trivial or insignificant it seems.

The upsurge in interest in doing research exhibited by nurses themselves is encouraging. Qualified professional nurses are earnestly seeking means for answering the many problems that are pressing for investigation and solution. It is gratifying that projects are beginning to appear with greater frequency from nurse investigators. In our zeal to meet this one of the criteria of a profession, we should be alert that what we report as research or even as studies can stand up under scrutiny of social scientists.

Before undertaking a study arm yourself with some of the excellent treatises on research. For an understanding of the principles involved and the step-by-step procedure "Scientific Social Surveys and Research"[1] by Pauline D. Young and "Methodology of Educational Research"[3] by Good, Barr, and Scates are helpful. Puffer's, "Practical Statistics in Health and Medical Work"[4] and Garrett's, "Statistics in Psychology and Education"[5] provide information necessary for the mathematical and statistical treatment of data.

As "must" reading before beginning each investigation and for re-reading whenever the going is difficult I suggest a pamphlet by Lent D. Upson entitled, "About Heuristics: A Letter From a Dean of Public Administration to his Graduates."[2] Reading it will help one regain a proper perspective about research faster and more painlessly than anything I know.

Summary

Research is the collection of facts about a specific problem, their measurement, their comparison with other facts and generally accepted truths, and the arrival at conclusions which must be in harmony with the stated objectives.

Service studies and research projects have in common a systematic planning of procedure and careful checking of results at each step. The service study has immediate and restricted application while the research project seeks the definition of basic principles that can be applied universally.

Research in the social sciences presents certain problems because of the complexity of society and because of man's lack of precise instruments of measurement and recording of social data.

Bias on the part of both the investigator and of concerned social agencies and groups must be considered in any study. A brief mention has been made of some of the methods of doing research and of some of the technics found useful.

The nursing profession is beginning to assume some responsibility for doing its own research. The individual investigators should consider very critically what is labeled as research to be sure it can stand the test of evaluation by the scientific method.

Industry has made major contributions to research. I can do no better than to conclude by quoting a statement which appeared in 1940 in an advertisement of the Gulf Oil Company. This puts quite succinctly what I have been attempting to say about research.

1. It is a state of mind that is discontented with things as they are.
2. It is a pair of eyes that yearn to see through the curtain of obscurity to fact.
3. It is a hand wielding a knife to cut a thing down to its smallest particle—and then to cut open the particle.
4. It is a brain for which there is no peace without knowledge and understanding—and no end to either.
5. It is a soul more concerned with mankind than with self—more anxious for progress than for triumph.
6. It is a man—indomitable and uncompromising.

This paper was presented before the Public Health Nursing Section, American Public Health Association, at the annual meeting in St. Louis, Missouri, October 31, 1950. It appears also in the *American Journal of Public Health*, June 1951.

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THE SIMPLEST way of getting some idea of what psychological maturity means is to go back to the child. Being childish—physically weak and dependent, mentally ignorant, emotionally unstable, socially irresponsible—is not being mature. Philosophers from Socrates to Overstreet have used the device of defining maturity as something which is not childish. To Epictetus the difference between immaturity and maturity was the difference between the ignorance of children and the knowledge of adults; "for they [children] are our equals so far as their knowledge permits." St. Paul tells us that when he was a child he spoke as a child, understood as a child, thought as a child, but when he became a man he put away childish things. Overstreet, in *The Mature Mind*, uses as criteria of maturity the opposites of the ignorance, the irresponsibility, the inarticulateness, the self-centeredness, the seeing in part and thinking in part with which the child is born.

Health Bulletin for Teachers, March 1951.

The Internship Program – Is it Sound?

ELEANOR W. MOLE, R.N.

IN FEBRUARY 1951 the internship program carried on by the Visiting Nurse Service of New York and the Visiting Nurse Association of Brooklyn in cooperation with three universities* completed its fourth year. During that time experience has given us conclusive proof that this is an established pattern of student work through which the intern furthers her professional growth as a beginning public health nurse or as a supervisor. Use of the words internship and intern in connection with this program has been criticized as inaccurate but we have not been able to find a more descriptive title.

The internship program is a student work experience extending through one full year. It is conducted for two groups: for the beginning public health nurse and for the advanced student preparing for supervision in public health nursing. During the first semester the student works a four-and-a-half-day week and takes two courses at one of the participating universities. She receives field work credit from the university for her first two months. Since observation and graded experience are planned on the basis of an entire year, there is no actual break between the field and staff activities. After the first semester the intern works a full five-day, forty-hour week, as do regular members of the staff. She receives a salary paid monthly over the entire twelve-month period and may, of course, continue her university work on the same basis as that permitted other staff members.

During the past three years many questions concerning the success of the program have come to the universities and the two service organizations. Let us take up some of the most frequent of these and see to what extent we can answer them.

1. What has been your experience in accepting interns and how many have completed the program?

At the outset of the program admission requirements were defined as follows:

a. Registration as a student in public health nursing at one of the affiliated universities.

b. Completion of at least one semester of university work, including basic sciences, social sciences, and related courses, or candidacy for a master's degree, providing the bachelor's degree program included the necessary courses.

c. Satisfactory university records and favorable reports on personal interviews with agency personnel.

d. Admission only at the opening of the university semesters, in October and February.

Sixty-four interns, entering the field, thirty-two in each agency, have completed or are in the process of completing internship in public health nursing. Eight failed to complete the year. The reasons for withdrawal were marriage, illness, and, in three instances, lack of genuine interest in public health nursing

* Nursing Education Divisions of Teachers College, Columbia University, New York University, and St. John's University, Brooklyn.

Miss Mole is executive director, Visiting Nurse Association of Brooklyn, New York.

which became evident during the first few months.

Eight supervisory interns have completed the program. Three, whose records during the first few months were unsatisfactory, did not continue.

2. Has the internship program recruited new staff and supervisory nurses and do you consider them more valuable because of guided experience?

Of forty-six beginning interns who have completed the internship twenty-six have become permanent staff members. Of those in the advanced group three were appointed to supervisory positions within the agency.

Our experience has been that the staff nurse who has completed a year's internship progresses faster and is ready to take special responsibility sooner than a new appointee. This is clearly shown by the records of former interns who have joined the staff of the Visiting Nurse Association of Brooklyn. Two have served as chairmen of the staff council. One, six months after her appointment, was made senior adviser; another, after an additional year of staff nursing, became an assistant supervisor; while a third applied for internship in supervision. Two are teaching mothers' classes and two are working in day care centers. One was sent on an exchange staff basis to Tennessee and three were assigned to the Red Hook-Gowanus Community Nursing Service. The staffs of the Bureau of Public Health Nursing, New York City Department of Health, and the Visiting Nurse Association of Brooklyn are combined in the Red Hook-Gowanus District to give service covering the entire field of public health nursing, including school nursing, in that area.

The experience of the Visiting Nurse Service of New York has been comparable to that of the VNA of Brooklyn.

3. Do nurses so prepared feel that the experience has been valuable?

It seems sensible to let the nurses tell for themselves what the program has meant to them.

Doris Schwartz, now studying at the University of Toronto, and for a time a member of the Red Hook-Gowanus Community Nursing Service where her internship period was followed by staff experience, writes in part: "I had superbly competent and understanding supervision in the field and in the office. No obvious 'student status' existed and I found that the increased allotment of time enabled the intern to assume full staff nurse duties while continuing to get more supervision and gain broad experience.

"By varying the schedule, my program during the year included full responsibility for a public school health program of three or four sessions a week for more than one semester; approximately four half-days a week in the field; clinic assignments, usually two half-days a week, with sufficient time for observation in the other services covered by our agency's combined program. These included mothers' classes in the voluntary hospital, and visits to day care centers, foster homes, and industries.

"I believe, as the proponents of the internship plan stated two years ago, that through the privilege of a full year of graded experience I was given 'an unusual opportunity to attain mastery of public health nursing practice.'"

Of her supervisory internship with the Visiting Nurse Service of New York, Mabel L. Johnson, who became a supervisor with the VNSNY, says: "The experience was one of the most professionally valuable that I have ever had. Having been away from public health nursing during the war, I felt the need of reorientation and though I had had supervisory experience in other areas, I had never had it with a visiting nurse agency. The internship was definitely a learning experience. In my present position as supervisor I am reaping many dividends from it."

4. From the standpoint of a service agency does the program justify the cost?

Mabel Reid, statistician for the Visiting Nurse Service of New York, has completed an evaluation of the internship program in that agency. In her report she states that "within

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Learning the Mental Health Approach Through the Chronic Medical Patient

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A PROGRAM OF inservice training in mental health for public health nurses has been carried on in the Psychosomatic Clinic and the Medical Division of Duke University Hospital since October 1949. Conducted under the joint auspices of the university and the North Carolina State Board of Health, the course is designed to give the nurse an orientation in the emotional factors involved in health and disease. It is financed by funds from the State Mental Health Authority.

Since the public health nurse works largely with people who are medically ill, the program is focused on the emotional factors involved in cases of chronic illness in the public medical wards. Interviewing and other technics are practiced while giving nursing care to the patients in the wards. The course includes individual conferences with supervisors and group discussions of the mental health aspects of cases encountered by the public health nurse in the field. From its beginning the program has been under the direction of a psychiatrist and since 1950 has been administered and supervised by a mental health nurse consultant.

Miss Burnett is public health nurse consultant in mental health, Duke Psychosomatic Clinic. Miss Sites is instructor in psychosomatic nursing, Duke University School of Nursing. Dr. Greenhill is associate professor of neuropsychiatry, Duke University School of Medicine and director of the Psychosomatic Clinic, Duke Hospital.

Need for program

It is increasingly evident that the 25,000 public health nurses at work throughout the United States can play a significant role in the developing movement to incorporate a mental health approach into general public health practice. Their access to the family and their many contacts in rural and urban communities place them in a unique position for casefinding, preventive practice, and referral for early treatment in the area of emotional disorders.

However, neither in her general training nor in her specialized education in public health has the nurse been adequately prepared to assume these responsibilities. With few exceptions the brief courses in the nursing of psychiatric patients given in the basic training have not brought into clear focus the mental health aspects of community nursing or the role of social and emotional factors in disease.

Inservice training programs to give public health nurses additional training in this field have barely made a beginning. The majority

have been in the form of institutes of one to several days duration, basically designed to orient the nurse to the need for a mental health approach in practice and to give her a survey of psychiatric disorders. A more intensive form of inservice training for nurses with emphasis upon social history-taking has been conducted in the Province of Saskatchewan in Canada. There is also the program for training nurse consultants in mental hygiene so that they may carry this education to the staff nurse. This, however, is not essentially inservice training, except when the consultant is working day by day in a local health department or public health nursing organization.

Organization and content

From the beginning the program at Duke University Hospital has been under the direction of a psychiatrist, and since April 1950 has been administered and supervised by a mental health nurse consultant. The faculty is composed of a psychiatrist with public health experience, an internist who is a specialist in psychosomatic medicine, a mental hygiene nursing consultant assigned by the state board of health as principal supervisor of the inservice training program, the instructor in psychosomatic nursing in the Duke University School of Nursing, a psychiatric social worker, and a psychologist. All the members have teaching responsibilities in the program, and all but the social worker and psychologist act in a supervisory capacity in following the progress of the nurses.

Selection of participants

Nurses of relatively high responsibility in the state public health system are given preference in the selection of volunteer applicants, in the hope of speedier dissemination of the mental health approach to their staffs. In addition, one nurse representative from the hospital medical service is included in each study group in an attempt to clarify and unify the work of the public health nurse and the hospital nurse and to encourage the infiltration of the mental health approach into the hospital nursing administration, teaching, and care of the patient.

To date eight groups of four to five nurses have participated in the program. This includes the director of the state public health nursing division, five consultants, seven supervisors of county health departments, and ten staff public health nurses. The remaining ten participants have come from the hospital field—the medical nursing administrator, five nursing arts instructors, two head nurses, and two assistant head nurses from the public medical wards.

Seven of the eight groups attended the course over a period of four weeks. Instruction began at noon on Thursday and ended at noon Saturday. However, a consecutive ten-day program was substituted for nurses from distant counties who would have found it impractical to travel back and forth each weekend. This began on a Thursday morning and ended at noon Saturday of the following week. Because of our limited experience with the second plan it is not possible to compare the relative merits of the two.

Content

The plan of instruction is a patient-centered orientation to the mental health approach. Didactic teaching is kept at a minimum. The lectures in specific areas of learning are focused on principles and technics. They are designed to help the nurse recognize, understand, and manage patient behavior and achieve a positive relationship with the patient.

The greater part of the instruction is centered upon nursing experience with chronically ill medical patients. It is believed that the average nurse is more motivated and less threatened when she assimilates a mental health approach by discovering the emotional factors in cases she handles in her routine work than when she is suddenly thrust into a program of orientation on psychiatric disorders.

In the nurse's work on the wards emphasis is placed on the use of the technic of indirect interviewing to arrive at positive nurse-patient relationships, an essential component of any nurse-patient contact.

Case conferences are conducted around patient material from the nurse's caseload. In

such group discussions the approach and technics learned in the course are applied to the usual work experiences of the nurse in the field. The curriculum consists of:

A. Lectures 7 hours
   1. Interviewing principles
   2. Beginning with a new patient (social service)
   3. Dynamics of human behavior
   4. Comprehensive nursing
   5. Nurse-patient relationship
   6. Introduction to some psychological testing (psychologist)
   7. Application of mental health approach to common public health problems
B. Case presentations and discussions 3½ hours
C. Time spent with patients 17 hours
   1. Nursing care 10 hours
   2. Preparation of nursing notes (verbatim recording) 7 hours
D. Supervision (formal) 6 hours
   1. Individual conferences
E. Participation in psychosomatic and psychotherapeutic (medical) conferences 12 hours

In this learning experience more time is devoted to giving bedside nursing care to a patient so that the interview technics can be integrated into the total care. Although we realize that any patient in the hospital could be a subject for study it is necessary to be selective for the public health nurses. Many of them have not been in contact with hospital routines for several years, and even in their daily work give bedside nursing care to few if any patients. In order that the anxieties of the nurse may be kept at a minimum in this core area of the training program, selection of patients is based on the following conditions:

1. That he or she not require complicated nursing care or treatment.

2. That the patient is on the ward and is thus available for either morning or afternoon care.

3. That the patient is one who communicates easily.

4. That the patient is not under direct therapy by a member of the psychiatric staff.

5. That the patient will remain in the hospital the greater part of or throughout the term of the nurse's program.

These patients are selected by the nursing consultant in cooperation with the medical house officer and head nurse of the ward and are assigned to the public health nurse. The nurse is responsible for the general care of the patient and in some instances gives medications.

Initial orientation

It is essential to prepare the nurse for reentering an unfamiliar but basic situation and to introduce her to the technics of communication taught in the program. This process includes participation in a discussion led by the psychiatric social worker concerning the different feelings people have about being sick, needing help, leaving home, and entering new situations, et cetera. Many nurses express their own anxieties about returning to the bedside, being in a learning situation again, and their fears of "doing more harm than good." A tour of the ward where the nurse will be working is arranged to familiarize her with its operation and with the personnel. A medical staff member discusses the purpose, objectives, and technics of interviewing, emphasizing minimum verbal activity by the nurse. The nurse is given a mimeographed sheet, "Suggestions for Helping your Patient to Talk," for present and future reference; it seems to fill her need "to have something in writing." Some time is devoted to discussing a method of recording verbal and nonverbal activities of both patient and nurse at each of her contacts with the patient. The importance of verbatim reporting is stressed.

Work with patients

The participating nurse usually has her first contact with the patient on the second day of the program. One of the nurse consultants is on the floor with the students, assigns them to their patients, is available for answering questions, and serves as a source of "support." The nurse is given the name of her patient and any special orders which will govern her care of that patient. The nurse is not informed of the nature of the medical problem in order that she may, through talking with the patient, learn of this herself. Otherwise, it has been found that her knowl-

edge of symptoms compels her to ask direct questions rather than to concentrate upon correct interviewing technics.

The nurse is told that a complete picture of the patient's troubles and symptoms is not immediately wanted unless the patient offers them to her. Instead, she is urged to practice "listening" to the patient and observing the way he communicates nonverbally. She is encouraged also to be aware of what her own feelings and activities are during her contact with the patient. It is hoped that in subsequent contacts the nurse will learn to focus on certain areas which have particular meaning to the patient. This preparation offers the nurse more security, lessens her anxieties, and encourages her to practice using interviewing technics.

Individual conferences

Following each recorded contact with her patient the nurse has an individual conference with the same faculty supervisor. This continuing relationship provides an opportunity to follow the nurse's progress closely. These conferences include study of the process involved in the following areas: the nurse's ability to focus on the verbal material being given by the patient, her faculty for recognizing and following up the verbal clues to social and emotional problems, and her ability to understand the dynamics and status of the nurse-patient relationship. This method of supervision, intense individual study of each verbatim recording, offers direction for the nurse's comprehensive care of her patient, provides a method for her to develop understanding of the emotional factors in health and disease, and helps her see the meaning of patient behavior.

Group discussions

The supervisory process is, of course, not limited to these individual conferences. Much can be learned from the nurse's behavior and contributions in group discussions about her own attitudes, needs, and growth in understanding. For example, at the completion of a case presentation from the field the leader asked, "What would be your approach to this situation now?" In the group discussion that followed several suggestions were made regarding the need to know more about how the patient and family felt about the physician's recommendation for plastic surgery. Most of the participants felt that in this situation, as in others, they were too ready and eager to "push" the need for certain procedures onto families without an awareness of the impact these had on the persons involved. One of the nurses, however, felt "more information from neighbors and the community resources" was needed. Another of the group spontaneously responded to this with, "If you did that you would only be adding more facts to the picture without knowing more about the feelings of the family." The discussion continued for several minutes before the nurse who had previously been in the minority said, "Why, what we've been doing all along is just getting data for the folder, isn't it? We've been taught to teach and to get information for our records, but we've forgotten the 'who' we are teaching." This nurse later discussed this realization further with the supervisor.

A second illustration of the opportunities for supervision in group discussions occurred when a nurse, in presenting a case from her district, described the family's socioeconomic status in the community in a derogatory tone of voice and compared the mother-daughter relationship with that of her own. Such measuring and judging of patients' social levels against her own standards had been apparent on several other occasions.

The leader interrupted the presentation to pose this question to the group, "What did you just hear Miss Blank say?" One of the group responded, "Isn't she comparing this family with her own? It is true that we don't know very much about this family, but isn't it possible that their present way of living may be an improvement over the way they have lived before? I don't think it is fair to judge them by known higher standards."

The following week the nurse who had presented the case came to the supervisor and asked for help in "learning how to accept people for what they are without making comparisons all the time." These illustrations offer evidence of the willingness of some

nurses to change stereotyped behavior patterns and indicate their ability consciously to put "new" knowledge into practical use.

Evaluation

Evaluation as a basic part of supervision is an aspect of this teaching method. Thus the immediate results of learning by the nurses are observed in individual conferences, in group conferences, in the self-evaluation check form kept by each nurse after each interview, and in the nurse's final evaluation of her experience in this training program. In these final evaluations are found, among others, indications of individual change in attitudes, realization of the importance of "listening," and broader understanding of the concepts of disease—what sickness means to individuals. The following samples from evaluations illustrate these:

I believe I will be able to integrate the interviewing technics into my daily work and thus make a definite contribution to recording in the family folder. . . .

I have a better understanding of comprehensive nursing care, and I am already thinking of several families in my area that I might now be able to help a great deal. . . .

I am more conscious of the need for and the importance of listening, rather than getting information by asking direct questions. . . .

This experience has not created any emotional experience that would be detrimental; it was a stabilizer. I certainly have a better understanding of how I can work with the nursing staff in planning inservice meetings. . . .

When I came to Duke I had high hopes of getting something that would enable me better to help my patients. At the end of the first week I felt, "Oh, Lord! How much harm have I done in the world with my own opinions!" I admit that I was skeptical. Why, the whole thing was against everything that I had been taught; for instance, "Never miss an opportunity to get in health teaching." I thought the germ theory was being completely disregarded.

At the end of the second week I was still confused. I had seen that patients did have a need to talk and that perhaps they were not as anxious for my professional advice as I had assumed. At the end of the third week my confusion was a little more settled, or perhaps "cleared" is a better word. I began to see that the germ theory was not disregarded and that what was being offered here was a more complete picture of the causes of illness: not only what effect the germ had on the person but what effect the whole emotional life of the patient had on the germ, as well.

During this week I presented a tuberculosis case to our group for discussion. Each of the nurses saw immediately that I had been teaching and giving advice but never once had allowed the patient to talk about his tuberculosis. I knew that he belonged in a sanatorium, so I concentrated my effort on getting him there. The more he objected, the more I taught and insisted that he go. When he finally was admitted to the sanatorium the whole office staff said, "Congratulations." I know now that they were not in order. I had not done a good job. This fact was further shown by his leaving the sanatorium against advice and coming home where he had wanted to be all the time. I know I have learned a lesson here. What I can do or will do with this knowledge remains for me to evaluate later.

From these evaluations the ability of individual nurses to apply a mental health orientation to their general public health work is estimated and a follow-up study to appraise the validity of these estimates is in process.

In the year this program has been in effect the following observations can be related: Once the nurse really gets herself into the interviewing technics and can feel the satisfaction that comes with the realization of what she has accomplished with them, she becomes enthusiastic and the resistances—"We don't have time." . . . "This is for specialists" —lose their value to the nurse. As she feels more secure in her "listening" role the need to "tell" and to "health-teach regardless" declines from its primary position in a nurse's visit to one more attuned to the patient's needs. There is a definite realization by some nurses as they present cases for group discussion of the lack of information they obtain regarding their patient's feelings and family relationships. The inefficiency of many visits to a patient in order to get him to "do" something or to "health-teach and supervise," without first exploring the feelings the patient may have regarding what he is being asked to do or to learn, is also recognized by some of the participants.

Summary

This inservice training program for public health nurses is an experimental approach to the teaching of mental health principles and technics as they apply to everyday problems in public health. The methods of instruction are patient-centered with but a minimum of didactic teaching. Emphasis is placed on the correlation and recognition of nurse and patient behavior through the study of interviewing technics and through their use while giving nursing care to a chronically ill patient on a medical ward. Evaluation of the nurse's progress in this program is a continuous process achieved through individual conferences with a faculty supervisor, through observations in group conferences, and through the nurse's self-evaluation. The principles of emotional health offered in this program are constantly being applied to the common problems in public health brought in by the nurses. The immediate results are evident, and follow-up plans for determining sustained learning and application by the participants are now under way.

This program is but one of several possible methods and is necessarily influenced by regional characteristics and by the teaching methods of its faculty. This preliminary report is offered for evaluation and testing by others in the hope that in the course of time common agreement may be reached on the most effective methods of providing this inservice training.

The Internship Program

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the framework of the agency program the beginning and supervisory interns who completed one year with the VNSNY have had opportunities to observe and participate in a variety of activities to the extent expected when the internship program was planned. . . . From the agency's point of view, the internship is not an uneconomical venture."

Teachers College, Columbia University, is keenly interested in making an analysis of the entire internship plan as it has been carried on in the two agencies during the past four years. It is hoped that this study may be under way in the near future.

At a recent meeting of the original planning committee, composed of representatives of the universities and service agencies, the program was reviewed and recommendations considered for the following semester. The advantages to the intern of a closer relationship between the universities and the agencies were discussed and an agreement was reached that toward the end of the year one or two conferences should be planned in which all interns and university and field personnel would take part. A recommendation was also made that the four-and-a-half-day week be continued through the second semester in order to give time for additional university courses. This plan went into effect in February 1951.

In 1947 the first report on the internship program in this magazine** ended with this statement: "We realize that the internship plan is in a developmental stage. We believe that with joint university and agency planning for her educational preparation, the intern will receive experience which will help her to be a valuable practitioner in the field of public health nursing."

It is the belief of those of us who have watched and taken part in the program that the original objectives set by the committee have been attained and that the plan has been a success.

** Wilson, Dorothy, and Mole, Eleanor W. VNA internship program. PUBLIC HEALTH NURSING, November 1947, v. 39, p. 560-561.

Posture and the Nurse

The nurse's role in recognizing the factors contributing to postural defects and what she can do to prevent them.

SONYA WEBER, D.Sc.

PEOPLE IN GENERAL think of posture only in terms of beauty and judge it by its esthetic value alone. Among professional groups, however, many orthopedists, pediatricians, and specialists in physical medicine and rehabilitation realize the importance of good functional posture in its relationship to health. Parents and teachers often complain about the ungainly appearance of children with poor posture. Tired women complain of chronic backaches and men of "strained" backs from lifting heavy things or from participating in sports. Very few people, however, relate the chronic backaches or the sudden occurrence of an acute back strain in the adult to poor posture developed in childhood.

Actually it is only within the last few years that we can quote clinical reports linking posture to health. The Low Back Clinic of Presbyterian Hospital, Columbia University Medical Center,* found, in thorough examination of 300 patients complaining of pains in the lower back, that 60 percent were caused by muscular imbalance (poor posture) and a further 20 percent were caused by osteoarthritis combined with poor posture. Dr. Hans Kraus found in his study of 143 cases with painful lower back conditions that 77 percent were caused by poor posture.

Dr. Weber is instructor in physical medicine, Columbia University.

These reports show definitely that posture should not be evaluated by beauty standards alone but mainly by the standard of good body function. Many men and women suffering from backaches and a tired listlessness could be helped by correction of their posture.[1] Well functioning body mechanics should finally be recognized as an integral part of good health.

The Health Council of Greater New York has organized a workshop committee to discuss questions on posture and to investigate school facilities to improve the posture of school children. All members of that committee are aware that a great job of popular education will have to be done to bring about a change in attitudes towards posture.

Who is to do this job of promoting better posture?

Most people think it should be the physical educators, but they alone cannot do the whole job of promoting better posture since they come in contact with the child only when he reaches school age and when he is well. It is the public health nurse at home and in

* The Low Back Clinic was started by Dr. Barbara Stimson in 1946 and continued by Dr. Sawnie Gaston in 1947. It consisted of a group of physicians: an internist, orthopedist, radiologist, urologist, gynecologist, neurologist, physiatrist (physical medicine) and psychiatrist.

clinics, the school nurse, the camp nurse, and of course the nurse in the hospital or home caring for the sick, who will be able to do a great deal more for better posture.

By what standards should posture be judged?

It should be judged by standards of efficiency. In correct posture the activities of the body are carried out with the least expenditure of energy. The bony structure is held erect by the neuromuscular apparatus. Tension in the muscles—equivalent to energy spent by the muscles—enables us to stand. The greatest efficiency is achieved therefore with an alignment of the body segments (head, trunk, lower extremities) which need a minimum of energy to hold them up. The center of gravity of each segment must be held perpendicularly over the center of the base. Wells has defined the center of gravity as an imaginary point representing the weight center of the body.[2] One might compare the body segments to blocks. In building a column with blocks one must place them squarely on top of each other to form a stable structure. The same is true of the human structure. The tension in our antigravity muscles, the extensors of our body, must be properly balanced by the opposing muscle groups to hold the vertical alignment. If this balance between them is lost and one group becomes stronger than its opponents, a segment of the body is pulled out of alignment causing a loss in efficiency of function and resulting in poor posture.

We name postural defects by the skeletal structure of body regions where they occur, but it would be more exact to describe these conditions by the muscles which cause them. We speak of a person as having round shoulders or a humped back or a sway back. If these conditions are not caused by bone malformations but are purely postural it would be much more correct to describe them in terms of muscle weaknesses or shortening of muscles. Round shoulders or dorsal kyphosis could be described as a shortening of the pectoral muscles and a weakness of the upper back muscles; a sway-back or lumbar lordosis, as shortened hip flexors and lower back muscles with weakness of the extensors of the hip joint and abdominal muscles.

Even though good posture varies slightly in each individual there are some general rules which help us to evaluate it:

Body symmetry.—Seen from the front the spine must lie in the sagittal plane which passes vertically through the body from front to back, dividing it into two equal halves.

Body alignment.—Seen from the side the following points must be in a vertical alignment: the lobe of the ear, the center of the shoulder, the center of the hip joint, and a point slightly in front of the ankle bone. In this alignment the line of gravity which Wells[2] defines as a vertical line passing through the center of gravity to the floor, falls slightly in front of the ankle bone. The weight of the body is centered over the middle of the arch in the foot.

If we think of posture more in terms of dynamic function than of static position we must not only examine posture for the symmetry of the body and its vertical alignment, but we must test the muscles holding the body erect for elasticity and power.[3]

When and how does poor posture develop?—three danger periods.

1. *During the first two years of life erect posture evolves in the child. These might be called the first danger period.* The newborn baby is unable to sit or stand. If all muscles of the newborn infant were to increase their power or tension equally the child would hardly be able to stand and most certainly not in normal erect posture. Many changes take place in the relative position of the skeleton because the degree of increase in muscle power varies greatly in different muscle groups.

The newborn baby has flat feet. A fatty cushion covers the sole of the foot. When the plantar muscles increase in tension the fat disappears and the arch of the foot develops. It acts as spring and shock absorber at each step. The knee and hip joints are flexed at an acute angle. If one pulls the legs of a healthy infant down they snap back into a flexed position as soon as the hold is released. This shows that the flexors of the knee and hip joint have more tension than the extensor muscles. If the child is to stand erect the tension in the extensor muscles must increase,

the muscles will shorten, and the opposing flexors must proportionately decrease in tension and lengthen. The acute angle at the knee joint must increase so that calf and thigh are in a straight line of 0-180 degrees. In the hip joint the acute angle between the length axis of the femur and the symmetrical axis of the pelvis must increase. In normal erect posture this angle should be approximately 165 degrees so that the pelvis has a slight forward tilt.

The spine of the infant is very flexible. Lying on a horizontal flat surface it will be perfectly straight. In erect posture the spinal column has a slight curve forward in the low back, a lumbar lordosis. The degree of this curve is conditioned by and dependent on the proper tilt of the pelvis. The upper back curves slightly backwards in a dorsal kyphosis and the neck slightly forward. In erect posture the head is balanced on these curves and countercurves of the spine so that its center of gravity is in vertical alignment with the center of gravity of the body. The eyes should look straight ahead and be on a horizontal plane.

The infant's ribs lie at an angle of 90 degrees to the dorsal spine. In erect posture the sternum and sternum end of the ribs sink so that this angle is reduced to approximately 70 degrees. This lowering of the ribs changes the shape of the thorax from a completely circular to an oblong circumference. The angle of the ribs to the spine and the amount of dorsal kyphosis are interdependent. This is caused by the very limited motion in the joints where ribs and spine articulate.

The infant has abdominal breathing. The lungs expand by excursions of the diaphragm into the abdominal cavity. The adult should have mixed breathing (abdominal and chest) by also raising the ribs from their slanted position to the horizontal at full inhalation.

The infant's abdomen normally has a larger circumference than its chest. In erect posture the circumference of the abdomen should be smaller than the chest circumference. The abdominal muscles should increase in tension so as to hold the abdomen in.

These changes all take place gradually. The creeping child begins to strengthen all antigravity muscles and stretch the opposing hip and knee flexors. Creeping is therefore an important preparatory stage to good erect posture.

Danger.—A danger to good functional posture is to encourage a child to stand and walk before the proper adjustment in muscle tension necessary for the erect position occurs. When the child holds on to objects in its first attempt at erect posture he should not be coaxed to stand or walk by holding and pulling him up by the hands. If the adjustment at the knee and hip joint is not completed the child will compensate for it by curving the spine backward so as to bring the head up. The pelvis will remain at an angle of less than 165 degrees. The weight of the abdomen increases the pelvis tilt, pulling the spine into a stronger lordosis. To compensate for the lumbar lordosis, a secondary increase in the dorsal kyphosis increases the normal downward slant of the ribs so that the sternum presses on the abdomen, increasing the forward tilt of the pelvis and lumbar lordosis further. This in turn must increase the compensatory dorsal kyphosis which closes the vicious circle of poor posture. Parents should be warned of this danger.

Prevention.—To further the normal development of good functional posture the bed of the baby should be firm and flat. Infant gymnastics help strengthen back and abdominal muscles. Simply placing the baby in a prone position encourages him to raise head and shoulders, thus strengthening the back muscles. Helping the baby raise himself from supine to sitting position strengthens the abdominal muscles. The child should be encouraged to creep. Standing on soft surfaces such as the crib mattress should be avoided since the foot drops into eversion, and the arch of the foot is weakened. Footwear should be chosen carefully as to size and shape. If stockings are too small they are just as confining as tight shoes.

The nurse at well baby clinics and health stations can do much to promote the normal development of good posture by teaching these simple rules to parents.

2. *The teen age might be called the second danger period.*

The growth of the long bones is often so rapid that the muscular development cannot keep pace with it. The child drops into a typical posture of fatigue. Long school hours make matters worse. It is a physiological law that muscles shorten permanently if held for prolonged periods at a smaller distance than their normal length. The normal length of a muscle is the distance from origin to insertion with the joint in neutral position and the muscle at rest. The opposing muscles will be stretched to a longer distance than their normal length and weaken.[4]

Dangers.—A child bending for hours daily over a school desk can easily develop round shoulders as the pectoral muscles are shortened in this position. The opposing upper back muscles, the trapezius and rhomboidii, are overstretched and weakened. Habitually carrying heavy books on the same side or sitting sideways while writing may cause unilateral imbalance of muscles and develop a lateral curvature, a scoliosis.[4]

Only systematic exercises to increase the tension and so shorten the overstretched muscles, and to increase elasticity and so lengthen the shortened muscles can restore proper balance.

Prevention.—Correct height of tables and chairs, well fitting clothes and shoes, and sufficient and proper outdoor activities to counteract the effects of long school hours will help to prevent muscular imbalances during the school year. This might be considered solely the job of the physical educator, but the teacher and the school and camp nurse also carry some of the responsibility for recognizing postural defects at this stage and can help to correct them.

3. *Illness enforcing prolonged bedrest is a third danger period.* It may occur at any age and repeatedly. Growing children are particularly endangered if childhood illnesses require repeated bedrest, because the bones are still growing. But adults too, in spite of their more stable postural pattern, will develop muscular imbalance during prolonged bedrest.

The hospital nurse, the private duty nurse, or public health nurse caring for patients at home can do the biggest job of preventing poor posture. The posture-conscious nurse is aware that muscles will shorten permanently if held in a shortened position over prolonged periods. Persistence of such a position may finally result in fibrous changes in the muscle tissue causing lasting contractures. A patient past the acute stage of illness but in need of continued bedrest is most apt to develop such muscular imbalances.

Dangers.—Propping the head and shoulders on pillows tends to shorten the pectoral muscles and overstretch the upper back muscles. A pillow placed under the patient's knees or raising of the hospital bed at the knees holds the hips and knees in a flexed position, shortening the flexor muscles of these joints. The weight of bedclothes pressing on the feet keeps them in a drop-foot position shortening the gastrocnemius soleus muscle group. Even if a foot cradle is used to prevent pressure the weight of the foot itself pulls these muscles down. When the patient is ready to resume normal life he has to hold his body erect, not only in a generally weakened condition but with a muscular apparatus in which the proper balance has been lost. This is often the beginning of serious postural defects.

The nurse can do much to prevent these ill effects of bedrest.

Prevention.—All muscles should be put through the full range of motion daily. This can be done without much loss of time or inconvenience when the sponge bath is given. Lying supine on the flat mattress without pillows extends hip and knee joints and straightens the spine. When the foot is washed it should be put through its full range of motion, with stress on dorsiflexion, while the knee is held down on the flat surface. This will lengthen the gastrocnemius soleus muscle group. A foot cradle should keep the bedclothes off the feet and a foot support pushed against the soles of the feet can be used a few hours daily to prevent the feet from dropping. The leg can easily be raised perpendicularly to the body with the knee straight so that the hamstring muscles are lengthened. The arms should also be put through the full range of motion at each joint, particularly into abduction and elevation to stretch the pectoral

muscles. If a tendency to round shoulders is noticed a small pillow or pad made of folded turkish towels could be placed under the center of the upper back when the patient is lying supine to counteract dorsal kyphosis. This could be done while bathing the extremities. While washing the back or giving the alcohol rub the patient should rest his head on his hands. This position again will help to stretch the pectorals and counteract dorsal kyphosis. In this prone position after the legs have been sponge-bathed, they should be lifted backwards, forcing the hip joint into full extension and stretching the hip flexors. Convalescent exercises may be added later.[4]

In this manner the nurse can prevent to a great extent muscle shortening and muscle contractures. Most nurses put their patients into these positions and go through the movements, but it is important that this should be done with full consciousness on the part of the nurse as to *why* she is doing it. Only a posture-conscious nurse will perform the movements correctly and systematically, and this is necessary to counteract the long hours of flexed positions and the resulting muscle contractions.

What can be done to prevent the loss of muscle power?

In chronic diseases or in any illness enforcing prolonged bedrest, well graded, power-building exercises can be used. However these must be carried out under the direction of the physician only. Particularly after abdominal surgery and after childbirth abdominal power-building exercises are prescribed by many physicians. In such cases the nurse may have to carry out the exercise program and teach the patient. In orthopedic cases the exercise program is a major part of the treatment and is usually carried out by physical therapists. In all but the orthopedic cases the responsibility of preventing muscle imbalances will rest mainly on the nurse.

Postural defects caused by bedrest vary greatly in degree of severity. If they are slight they may go unnoticed for a long time. If they are severe enough to pull a body segment distinctly out of the vertical or symmetrical alignment they will be obvious immediately when the patient resumes normal activity.

The following case illustrates the importance of preventing muscle imbalance during illness. At the Posture and Therapeutic Exercise Clinic of Vanderbilt Clinic two girls were admitted. Their ages were eight and nine and a half. Analysis of the posture of both girls showed shortened gastrocnemius soleus muscles and hamstring muscles. Their pelvic tilt was increased by shortened hip flexors, weak gluti, and weak abdominal muscles. Their dorsal kyphosis was increased beyond the normal by shortened pectoral muscles pulling the shoulders forward, overpowering weak upper back muscles, and producing a narrowed chest and winged scapulae. Aside from these bilateral defects in posture they had developed a distinct unilateral deviation of the spine, a scoliosis. Marie had a right dorsal and left lumbar curvature and Jane, a left dorsal and right lumbar curvature.

The history revealed that both girls had gone through a contagious children's disease and had been kept in bed for a period of more than four weeks. They had been well enough after a few days to sit up in bed and play. The mother kept them in bed for fear of complications and thought herself especially careful. Actually they had occupied twin beds with a table placed between them for taking their meals and playing games. Marie had been sitting up with her left foot folded under her so she sat with her right hip raised, turning and bending over to the left, and Jane did exactly the opposite. Both girls spent the greater part of the day in this position, leaning towards each other over the bed table. This explained the development of two identical lateral deviations of the spine in opposite directions. It took many months to correct their scoliosis and general posture defects. The scoliosis at least could have been avoided easily by simply interchanging the beds every day.

It is certain that in these three danger periods the nurse has an opportunity to prevent postural defects herself or to teach parents or members of families caring for the growing child or patient.

Occupational posture defects occur whenever any one specific position is held during the greater part of the day. Probably the most widespread and generally known condition is painful flat feet or broken arches. A close second is backaches. The nurse herself is apt to develop these occupational troubles in the long hours of duty standing or walking or bending over patients' beds.

In a campaign for better posture the nurse as teacher and adviser of the public is invaluable. Knowledge of the dangers to good posture and of the basic principle of prevention and treatment will not only enable the nurse to help and teach others, but also to safeguard herself in her strenuous work of service to the public.

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Reprints of this article will be available from JONAS, 2 Park Avenue, New York 16, in about six weeks.

Comments on Dr. Weber's Paper

Public health nurses are well aware of the patient with the chronic backache or with an acute back strain. The author of this article has shown how many of these low back conditions in adults are related to poor posture developed in childhood. Having had considerable experience in treating postural defects she has in this article pointed out that the public health nurse has a responsibility in promoting better postural habits in the growing child. In addition she can do much while giving care to patients with acute and longterm illnesses to prevent postural defects from developing. Dr. Weber emphasizes the necessity of carrying on a tremendous program of popular education in order to bring about a change in attitudes toward posture. Public health nurses, aware of their responsibilities, will recognize a true challenge in promoting better posture and preventing serious postural defects. Excellent suggestions are given to assist nurses with this.

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Inservice Education in Cancer Nursing

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THE FIRST TWO sections of this outline on cancer nursing inservice education appeared in the May issue. The outline, which utilizes the problem solving approach, is designed for use in developing educational programs to keep nurses aware of the rapidly changing knowledge and technics in the cancer field. Sections III and IV follow.

Suggested Outline—Cancer Nursing Inservice Education

III. CANCER DISCOVERY AND DIAGNOSIS

Statement of Problem:

The public health nurse stopped at the Brown residence to teach the grandmother how to prepare the supplementary formula for the newborn baby. During the conversation the grandmother, aged sixty, confided to the nurse that she had noted some spotting during the past weeks.

1. What immediate action should be taken by the nurse relative to the grandmother?
2. What subsequent action should be taken by the nurse?
3. What knowledge must the nurse possess?

Content

A. Early discovery of cancer
   1. Values—curability
   2. The physical examination as a method
   3. Forces motivating desired behavior
   4. Discovery or detection facilities
   5. Role of the nurse in early discovery

B. Diagnosis of cancer
   1. Special methods of establishing a diagnosis
   2. Role of the nurse in diagnosis
      a. Preparing patient for experiences
      b. Helping patients and family to meet related sociological and psychological problems

C. Follow-up action
   1. Responsibilities
      a. Patient
      b. Family
      c. Nurse
      d. Physician
      e. Tumor clinic
      f. Health department
      g. Hospital

Suggested Activities

1. Discuss how you would stimulate a person to seek medical care.
2. Discuss "problems" that might prevent one from seeking medical care. How can these be met?
3. Discuss methods of getting patients to their physicians earlier.
4. List the public health nurse's opportunities for early discovery. Discuss areas needing improvement.

5. Show film: *Precancer Diagnosis of the Cervix by Cytology.*
6. Evaluate your own physical examination as a means of discovering cancer.
7. Show film: *Cancer: The Problem of Early Diagnosis.*
8. Discuss the best methods of answering laymen's questions about cancer without creating undue fear.
9. Observe service to patients in a tumor clinic and evaluate the tumor clinic visit:
   a. Doctor- and nurse-patient relationships
   b. Patient learning
   c. Effects of visit upon you
10. Discuss what the nurse can do to help the patient and family meet the cancer problem.
11. Have a panel discussion on the responsibilities of the team members in follow-up.
12. Review records and tabulate reasons for tumor clinic absenteeism. What can be done about them?
13. Using "role playing" technic:
    a. Counsel an early diagnosed cancer patient
    b. Interpret follow-up practices and procedures
14. Review admission and follow-up policies of the tumor clinic.

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FILMS

Precancer Diagnosis of the Cervix by Cytology. 16 mm. Color. Sound. Available through National Cancer Institute, Bethesda, Maryland.

Cancer: The Problem of Early Diagnosis. 16 mm. Color. Sound. Available through state health department library or state division, American Cancer Society.

IV. TREATMENT OF CANCER

Statement of Problem

District III is to be turned over to you. At this time you are being briefed about the caseload. The nurse giving up the district has three cancer patients about whom she is quite concerned: (1) Mr. Smith is in need of surgery for a lung lesion but is afraid and without funds. (2) Mrs. Jones has cancer of the cervix and is an outpatient at the city hospital. She is receiving x-ray therapy and is very uncomfortable because of skin reaction, nausea, and diarrhea. (3) Mrs. Wright who has carcinoma of the breast with metastases to the skull and pelvic girdle is in pain and receiving hormone therapy.

How can you meet these problems?

Content

A. Surgery
   1. Curative
   2. Palliative
B. Radiotherapy
   1. X-ray
   2. Radium
   3. Radioactive isotopes
C. Chemotherapy
   1. Hormones
   2. Chemical substances
D. Functions of the nurse in the treatment of the cancer patient
E. Nurse responsibility for follow-up

Suggested Activities

1. Discuss costs of treatment and effects upon family and community economy.
2. Discuss local resources for care of the cancer patient and for providing funds.
3. Observe radiotherapy and physical reactions.

   Discuss what the patient needs to know.

   Show film: *Radiotherapy High Dosage Treatment.*

4. Discuss the newer chemotherapeutic drugs. How and why are they used?
5. Discuss what should be included in the education of patient and family for treatment.
6. Discuss emotional factors involved in treatment and means of meeting them.
7. Discuss methods of meeting the public health nurse's needs in providing comprehensive home nursing care. List your specific needs.
8. Discuss and make plans for the home care of the cancer patient receiving:
   a. Radiation therapy
   b. Surgery
   c. Chemotherapeutic measures
9. Discuss local practices for continuity of patient care. Do they need to be improved? How?
10. Have a panel on teamwork in the continuity of care of the cancer patient.
11. Discuss and plan a home care program.

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Radiotherapy High Dosage Treatment. Nursing Series 02411. Sound. Available through U. S. Office of Education, Washington, D. C.

Sections V, VI, and VII of this outline—Nursing Care of Cancer Patients, Rehabilitation, and Education—will appear in the July issue.

Civil Defense

NURSING ASPECTS OF ATOMIC WARFARE

The National Security Resources Board sponsored a series of six courses of five days each in nursing aspects of atomic warfare during the period November 1950 to February 1951. The courses were conducted by the staffs of the Atomic Energy Commission and the USPHS. Ruth Freeman, nursing consultant, Health Resources Office, NSRB, and Frances E. Taylor, nurse member, Radiological Health Team, USPHS, served as nurse coordinators in planning and conducting the courses.

Three hundred forty-seven nurses from the United States and territories and, by special request, twenty-four nurses from Canada completed the courses. Nurses attended from every state but two; they came from the fields of public health nursing, hospital administration, nursing education, industrial nursing, and from the nursing organizations. The participants were selected nurses who could serve as key persons in their own states in developing similar programs for larger groups of nurses. Throughout the spring these nurses have been at work setting up manuals and teaching plans and aids. In many localities the first general courses have already been given.

NOTES ABOUT CIVIL DEFENSE

Civil defense is everybody's business, not just the federal government's. This was the keynote of a recent talk by Mr. Clem J. Randau, executive director, Civil Defense Administration. He said, "There is entirely too much apathy toward civil defense in certain sections of the country . . . Too many people feel that it can't happen here. This is just what the enemy would encourage . . . We deceive no one but ourselves if we refuse to take the path of realism—unpleasant though it may be. We must set up a larger program of citizen education than has ever been seen before. We must enlist the active support of every man, woman, and child to do whatever task each one can best perform. And we must do it *now*."

MUTUAL AID

The United States and Canada have signed a civil defense mutual aid agreement. The national civil defense authorities in each country will exchange information on the following:

1. Civil defense Federal, state and local legislation, organization and regulations
2. Research, development, standardization and availability of requirements of equipment, supplies and facilities
3. Training schools, courses, methods and publications
4. Working agreements among state, provincial and municipal authorities, and other agencies
5. Public information and education

The United States and Canada also will exchange civil defense personnel and make their training schools available to students of each country. Appropriate legislation will be sought where necessary to modify existing customs and immigration regulations and other pertinent laws affecting border controls.

Civil defense authorities of both countries expect to coordinate their planning as if no border existed between the United States and Canada. Such planning will cover the interchange of all civil defense supplies, equipment and facilities, including medical, hospital, fire-fighting, police, rescue, evacuation, welfare, transportation, communications and other similar services.

A Practical Approach to Home Safety

A. L. CHAPMAN, M.D.

THERE ARE SEVERAL important reasons why the public has remained aloof to the home accident problem. One of the most important reasons is that the problem has not been clarified sufficiently for the public so that a successful solution to it can be envisioned. Inherent in many of the solutions that have been proposed up until now has been the mirage that habit patterns can be changed by informational efforts alone. Unfortunately, most people instinctively know that this is, to say the least, impractical. Therefore they have shown little enthusiasm for home accident prevention.

If ever we are to enlist the wholehearted support of the public in a continued campaign to reduce the number of home accidents we will have to develop a preventive program that is practical above all else. Such a program must not consist of a reaffirmation of general principles. It must deal with the home accident problem in terms of people and money and times and places.

Basic Principles

There are certain basic principles that will have to be recognized when such a program is outlined.

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1. A program is practical only if it works.

2. No program can work if its success depends upon community ingredients which are nonexistent. Some of the ingredients needed to construct a sound community home accident program are interested personnel, financial support, community organization, public education and motivation, and official recognition, participation, and support.

3. No sporadic publicity program, no matter how eye appealing it may be, will ever solve the longrange accident prevention problem.

4. The home accident prevention program must be directed to those age groups and to those types of accidents that constitute the bulk of the home accident problem. There are no funds, time, or personnel to be wasted on unimportant aspects of the problem. It is not sufficient to concentrate our attention on "falls" as a category. We must be more specific than that. We must concentrate on more specific categories, such as "falls among people over sixty-five" or "burns among children under five."

5. Our educational efforts must be more sophisticated. It has been shown that throwaway, one-shot, so-called educational campaigns produce no lasting motivation. Motivation results from a continuing series of impacts. We must actually achieve a permanent training status for the public, or at

least for certain key members of the public.

6. Programs must be adaptable to communities that may vary widely in size of population, financial status, and home accident pattern.

7. Home accident prevention programs must be of such a nature that they attract widespread community participation. In this way the participants themselves become safety conscious and excel as "home safety salesmen."

The Problem in Parts

A beginning may be made along these lines by breaking down the 1949 total of 31,000 home accident deaths into categorical groups which are fairly discrete. These deaths may be considered under eight headings.

Falls among people over sixty-five years of age. Only 5 percent of the 15,700 home accident deaths from falls each year occur among people under forty-five; 85 percent happen in the age group over sixty-five.

Burns among children under five and among adults over the age of sixty-five. Of the 4,700 annual deaths due to burns, 52 percent occur in two age groups: 22 percent in children under five and 30 percent in adults over sixty-five.

Mechanical suffocation in infants. Although death certificates show that mechanical suffocation in infants occurs often enough to make this the fourth group in the list of causes, the Children's Bureau and many pediatricians and medical examiners now realize that many diagnoses of mechanical suffocation have been incorrect. Studies of a series of infant deaths reportedly caused by suffocation indicate that in a vast majority of instances the infants were victims of massive, overwhelming bacterial infection. Further studies now in progress appear to confirm these initial findings.

Poisoning among children under five and poisoning due to barbiturates. There are 1,400 annual deaths due to poisoning other than by gas. These deaths fall into two categories: poisoning in children under five and poisoning due to barbiturates.

Utility gas poisoning among persons over forty-five. Two thirds of the 1,200 deaths due to gas poisoning occur in this age group and most of them involve utility gas.

Deaths from firearms among children under fourteen years of age. Another 1,200 annual deaths are caused by firearms; almost one third of these deaths occur in children of this age.

General Preventive Technics

For each of these groups a reasonably concrete preventive program can be worked out. There are, however, four technics which are applicable to most types of home accidents. These technics deserve a fairly detailed discussion.

1. *Analysis and pictorialization.* If we ever are to be able to portray the extent of the home accident problem in any community it will be necessary to obtain some idea of the size and characteristics of the local home accident problem. We will have to investigate all reports of accidental deaths. Public health nurses, sanitarians, or properly instructed volunteers may be used to do the field epidemiology that will be needed.

Having obtained the best possible analysis of the local home accident problem the facts that have been found may be dramatized for the public by the use of good audiovisual materials.

2. *Selection and education of the index person.* This technic is a new one. It represents a new concept in home accident prevention. It is the antithesis of the current theory that habit patterns may be changed by transient or superficial educational programs. It is based on the assumption that children and oldsters are not going to change their habit patterns overnight and that someone else must accept the responsibility for their safety. This has been the weak point in our approach to home safety in the past. We have assumed falsely that by educational methods alone each individual could be made to accept a personal responsibility for his or her own safety. Experience has indicated that such an assumption is not warranted. Since the majority of home accidents occur to children and oldsters, our attempts to persuade them to take care of themselves have been very largely, if not totally, wasted.

We must find in each home situation the person best suited by age, by sense of responsibility, by intelligence, and by conscience to accept the responsibility for receiving the training that will enable him to protect children and oldsters in his care from fatal home accidents.

Whoever is selected will have to understand the gravity of the responsibility which is being assumed, will have to be willing to attend group conferences or home safety clinics, and will have to accept some type of home safety supervision.

It is not contrary to human nature to expect the index person to show more concern for the youngster or oldster in his charge than most of us show for our own safety.

3. *Inspection of premises and eradication of danger spots.* Now that sanitarians are finding some of their work in the field of infectious disease control lessened by successes in the control of these diseases, some of their time may be made available to make periodic home visits for the purpose of checking on the presence of home accident hazards. Certainly a poorly lighted cellar stairway is as dangerous to life as an overflowing garbage pail or a poorly screened privy, and should be of at least equal interest to the public health worker. Even public health nurses, as busy as they often are, perform less valuable tasks than checking off a home safety inspection form with someone in the household. Volunteer workers could find no better outlet for their pent-up sense of community usefulness than in visiting homes, under the guidance of the local health department or safety council, for the purpose of assisting home owners and tenants to remove home accident hazards.

4. *Detection and correction of physical impairments.* Many falls and burns and other home disasters are attributable to physical infirmities and disabilities. The correction of an eye defect may be all that is needed to make the home safe for grandma or grandpa. A proper diet aimed at overcoming nutritional anemia in an oldster may reawaken reflexes, the failure of which might result in a fall downstairs. Physiotherapy can be employed economically at home, under the guidance of a physician, to improve circulation in aging limbs and bring back some of their waning elasticity. Many other causes of dizzy and fainting spells, petit mal attacks, or paralyses, may be minimized by medical treatment. Physical infirmities per se, many of them amenable to correction, are important contributing factors in many home accidents.

Specific Steps to Prevention

In addition to the application of these four principal technics for preventing home accidents there are other technics that are limited to individual segments of the problem.

For example, the effective method of prevention of those suffocation and strangulation deaths that still occur would be to utilize some of the time that the mother spends in the maternity ward after her baby is born to educate her concerning safe methods of infant care and the importance of reporting mild illnesses at once. Never again during the child's life will there be such a splendid opportunity to interest the mother in the welfare of her infant.

The poisonings in the age group under five are, for the most part, preventable by the use of a little common sense. It is surprising that most parents underestimate or do not appreciate the monkey-like qualities of children who can, with little difficulty, climb on top of bathroom washbowls to reach easily opened medicine chests. The only logical solution to this problem is to lock the cabinet or to equip it with a fastener that fastens from the top. As for the roach pastes and rat poisons, the insect repellents and chloride of lime cans, the varnish removers and the ammonia bottles, the turpentine and other deadly concoctions that are so often placed temptingly within the baby's reach, there is nothing to be done but to place them safely on a high shelf, behind a cabinet door that fastens securely.

In the case of barbiturate poisoning there are several very practical things that can be done. Barbiturates should not be kept in the house in quantities sufficient to cause death. Overdosage with barbiturates has offered an all too easy way out for persons who are only temporarily suicide-minded. The wisest and safest thing to do is to pass and enforce

legislation designed to prevent the sale of barbiturates except by prescription. There are loopholes in the enforcement of such laws, wherever they exist, but their net effect has been to reduce the abuse of these drugs and thereby decrease the danger of accidents and suicides. The accidental poisoning of children with barbiturates can be prevented by the same measures that are designed to prevent poisoning with other noxious substances. Such substances must be kept safely out of reach. The index person should see to that.

Utility gas poisoning is another cause of accidental death which can be reduced drastically by the application of a reasonable amount of supervision. Utility gas poisoning kills more people than do firearms. You have to have a license in most states to use a gun and a license is required to operate a motor vehicle. Even pest exterminators are licensed. Yet anyone, no matter what his mental status is, or what his emotional stability is not, can purchase a gas stove and operate it. Systems for instructing purchasers in the proper and safe use of gas appliances are not the rule. There is no periodic checkup to see that appliances are properly installed and there is no way of knowing whether they are being used in a safe manner. Gas stoves and gas, itself, have been improved to the point where theoretically, at least, normal people should not be able to harm themselves. Unfortunately, completely "normal" people are at a premium. Therefore, it might be helpful if utility companies, which have been in the forefront of the home safety movement, could find some way of instructing users of gas stoves and appliances in safety technics and could make more frequent and thorough inspections of home gas installations.

Firearms are a special menace to youngsters in a home. There is only one safe place for guns in a home, particularly the empty ones—which too often are not empty—and that is under lock and key. A gun that a child cannot reach cannot blow his brains out. To temporize with this problem by suggesting that the gun be unloaded, that the breech be broken, or that the gun be disassembled, is to invite disaster.

Organized Community Effort

By breaking down the home accident problem into its more important parts we can more easily develop reasonably specific methods for dealing with each part. These methods and technics, because of their simplicity, are more likely to be understood and carried out by the laity than are more vague and general directives that cover all of the various types of fatal home accidents that might occur.

Right now several countries are rebuilding their civil defense organizations block by block because civil defense cannot be coped with centrally. An effective home accident prevention program, like a civil defense program, cannot be handled centrally. We will have to build the preventive home accident program person by person, block by block, community by community, until the people who are destined to be the victims of home accidents save themselves by joining hands to save others.

The facts are very clear. We are not investing enough manhours of labor, of instruction, or in organizational activities to warrant a reduction in home accident deaths. Until we increase our investment Johnny and Mary, dad and grandpa, will continue to burn themselves to death, asphyxiate themselves, poison themselves, break their necks, and in sundry other ways do themselves in. Home accidents can be prevented, but it will take organized community effort to do it.

This paper was presented at the 1950 National Safety Congress and was published in *Congress Transactions*. It is reprinted here by permission of the National Safety Council.

Reading List on Natural Childbirth

Prepared by Maternity Center Association, in New York, for the NOPHN *Nurse Midwifery Section, February 1951.*

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Training for Childbirth. Minnie Randell (nurse-midwife and physiotherapist). 3rd ed. London, Churchill, 1945. 119 p. One of the earliest presentations of physical preparation for labor.

The Substance of Mental Health. George H. Preston, M.D. N.Y., Rinehart, 1943. 147 p. $2.25. A simplified description of the characteristics of a mentally healthy person.

For General Information

Childbirth without Fear. Grantly Dick Read, M.D. N.Y., Harper, 1944. 251 p. $2.75. First book on natural childbirth published in the United States. Emphasizes philosophy and principles.

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Epilepsy Is Losing Its Punch!

DOUGLAS T. DAVIDSON, Jr., M.D.

YES, EPILEPSY IS losing its punch! Medical science and education have joined forces to take the power out of its wallop. Epilepsy has in the past been able to deliver a shocking blow to its victim and his family. The power of its punch is derived from two sources: first, the tangible handicap of periodic seizures; second, the stigma attached to the illness by a misinformed public. Often the sting of the stigma is harder to take than the inconvenience of the attacks.

Epilepsy is losing its malignancy on both counts. Today more effective methods of treatment make it possible for doctors to give substantial relief from seizures to eight out of ten affected persons. A better informed public is beginning to accept epilepsy not as a mysterious and shameful scourge but as just another nervous illness.

New treatment methods

Specifically, what are the recent scientific advances which have so changed the medical outlook for the epileptic—who numbers one in every 200 of us? The first is the widespread availability of the electroencephalograph or brain wave machine for diagnosis—a postwar development; second, spectacularly effective new chemicals for treatment, at least half of them discovered since the war; third, improved surgical technics.

Dr. Davidson is on the staff of the Neurological Institute, The Children's Center, Boston, Massachusetts.

Extensive use of the electroencephalograph, known as the "EEG," for the recording of the brain's electrical pulsations, has disclosed that minor irregularities in these pulsations or brain waves are present in about one in ten of us. Severe degrees of irregularity are associated with seizures. If these seizures recur repeatedly the condition is called epilepsy. When we realize that many millions have this brain wave irregularity the illness loses its exclusive character.

The EEG tells doctors what part of the brain is producing irregular pulsations, how severe the irregularity is, what medicine will probably be helpful in treatment, and, if the test is repeated, how effective the medicine has been and when it may safely be reduced or discontinued.

Science has revealed that while irregularity of the brain waves is the background for epilepsy the actual development of repeated seizures, or epilepsy, is dependent upon other factors not yet understood. We have learned that in persons whose tendency to seizures is great the actual attack may be set off by emotional disturbance, by extreme fatigue, by illness of any kind, by alcohol, and even by breathing too fast and too deeply. In some individuals the right combination of factors necessary to produce seizures may occur only once or twice in a lifetime, usually during infancy and accompanied by fever. One child in every fifteen will have at least one convulsion before his fifth birthday and yet rarely does the child go on to have recurrent attacks.

When we realize that some of the episodes we call night terrors—daydreaming, sleepwalking, temper tantrums, fainting, dizzy spells, or nervousness—show the brain wave irregularities seen in the more easily recognized forms of epilepsy, we find the illness is too common and has too many mild manifestations to be frightening.

Six powerful and effective antiepileptic medicines are now available—phenobarbital, mebaral, dilantin, mesantoin, tridione, and paradione. The last three have been developed since 1945. These chemical compounds provide the brain cells with the ingredients necessary for proper function and are taken daily like vitamins for long periods. Often when the brain waves have become regular and when the seizures have been absent for some time the patient can stop the medicine and get along perfectly well without it. Even though he must continue to take the medicine to remain free of attacks he can do so for years without harmful effect of any kind.

Certain persons whose attacks are not controlled by medicine and whose epileptic disturbance originates in a sharply localized area of the brain may be benefited by surgical removal of the guilty area. Results of such surgery have been improved in recent years by better selection of cases for operation and by more accurate localization of the epileptogenic area of the brain through use of the EEG, not only before but during operation.

Researches into the causes of epilepsy and the natural course of the illness have materially improved our understanding of the illness and, as our knowledge has increased, fear of the disorder and shame and stigmatization have lessened.

Management of seizure

School teachers and nurses are particularly likely to have to deal with a person having a seizure. Knowledge of the proper method of handling the seizure is a great comfort. First, one should know that all seizures, even the most violent, *tend to cease of their own accord,* that active measures to end an attack are seldom necessary, and these measures are the province of the doctor. Second, one should know that despite alarming symptoms, such as difficulty in breathing, choking noises, blueness of the lips, or failure to respond, the chances of a fatal outcome of a seizure are infinitesimal.

Grand mal

Seizures fall into three general groups. The first is the convulsive group, of which grand mal or the generalized convulsion is the usual form. In this type of attack there is often a sharp initial cry, followed by falling, stiffness of the limbs, distortion of the features, and then jerking or thrashing movements of the whole body. The tongue may be bitten, froth or saliva may appear on the lips, and occasionally bladder control is lost. The usual duration of the attack is less than five minutes and termination is often followed by vomiting or desire to sleep.

If such an episode occurs in the classroom or on the playground the teacher should reassure the other children and say simply that the child is sick but will be all right in a minute or so. Her efforts should be confined to preventing the patient from injuring himself by banging his head or bruising his limbs against the floor or furniture. Mouth gags for many reasons are not recommended. When the convulsion is over the child may be carried or assisted to a rest room where he should be allowed to sleep or rest until he has recovered. When he wants to he may safely be allowed to resume his studies without concern for a recurrence of his seizure. Prompt return to the classroom has two beneficial effects. It demonstrates to the other children that the illness was not serious, despite its spectacular nature, and it minimizes the problem of adjustment for the epileptic child.

Petit mal

The second group of seizures is the petit mal triad, consisting of petite absence or "staring spells," lapses lasting ten to twenty seconds, myoclonic jerks—sudden twitches or jerks of an extremity—and astatic or "drop" seizures. The absence is often mistaken for inattention or daydreaming because the only indication that the patient is completely

unconscious is the lack of animation in his expression for a few seconds. In such cases the teacher should avoid calling on the pupil to recite during the momentary blackout or should repeat her question if part of this has been missed during the attack.

Psychomotor

The third group of seizures is the psychomotor, also manifested by blank staring with complete amnesia about events during the seizure. Psychomotor attacks differ from petite absence, however, in lasting a longer time—several minutes as a rule. In this attack the patient may make chewing and swallowing motions, walk about, or fumble with his clothes as in a trance. He is usually confused and incoherent for a few minutes after the attack and may need to sleep a short time. Again, if the attack is noticeable the teacher should say in a matter-of-fact tone that the child is sick and will recover in a minute or so. Often the child may be led gently to the rest room where he may remain until he recovers enough to return to class. Because the child is confused in a psychomotor seizure he should not be forced into anything lest he become aggressive or belligerent.

Thus, forearmed with the know-how for dealing with a seizured child, the teacher can accept the epileptic in her class without apprehension and with the knowledge that she is teaching the chlidren more than they can get from books alone.

In summary, medical science and education of the public have created a more hopeful medical and social outlook for the epileptic, thus lessening the impact of this illness.

Given at institutes on epilepsy at Tampa and Miami in April 1950.

EPILEPSY AND INTELLIGENCE

Epilepsy per se ordinarily has little effect on mentality. Unfortunately, brain damage is encountered more frequently in children than in adults. Perhaps one third have suffered developmental defects or some injury to the brain at birth or later, or encephalitis may have complicated a childhood infection. The degree of mental defect often mirrors the degree of damage, and those most seriously affected join the long line pathetically waiting outside the doors of our state institutions.

However, the intelligence of youngsters who have not experienced brain injury corresponds to that of non epileptics of the same social stratum. Among 200 children seen privately and given the Stanford-Binet test the average I.Q. for those without evidence of brain injury was 106.5. Among 400 adolescents and adults given the Wechsler-Bellevue test the average score was 113.9. In both groups the average score of those with evidence of brain damage was ten points lower.

In the older undamaged group 30 percent had an I.Q. of 120 or more, mentally superior classification. The intelligence scores of patients attending a public clinic are significantly lower. The failure of seizures to depress mentality is best shown by twins. We have studied 125 twin pairs affected by seizures. For example in one ten-year-old identical pair the I.Q. of the normal boy was 179 and the I.Q. of his epileptic brother was 182.

—From "Epilepsy—A Problem in Public Health" by Dr. William G. Lennox in the April 1951 issue of *The American Journal of Public Health.*

National Conference On Chronic Disease

THE BASIC APPROACH to chronic disease must be preventive. This is the core philosophy of the Commission on Chronic Illness and the keystone of the National Conference on Chronic Disease, held in Chicago in March. Delegates from forty-six national health groups attended the three-day working conference.

The background for the meeting was built up during the first morning when papers were presented by Dr. David Seegal, professor of medicine, Columbia University; Dr. Leonard A. Scheele, surgeon general, USPHS; and Dr. Morton L. Levin, director of the commission. Leonard W. Mayo, chairman of the commission, presided at the opening session. Later the conference members divided into four working sections to evaluate scientific data and to consider professional education, community organization, and public information in relation to preventive programs. The goal of the conference was to review the available knowledge about chronic diseases and arrive at ways of applying this knowledge more effectively.

Two aspects of prevention were discussed: primary and secondary. *Primary prevention* refers to the prevention of the occurrence of chronic disease and of the important chronic complications or sequelae of disease. *Secondary prevention* relates to the prevention of subclinical asymptomatic forms of disease from progression to more severe stages by the detection, diagnosis, and treatment of subclinical or preclinical stages of chronic illness.

Early diagnosis can be secured through an educational campaign and continued emphasis upon periodic physical examinations, especially for those over fifty years of age.

Dr. Scheele referred to the fact that for most people prevention of chronic illness is an "intellectual concept." Today prevention is almost exclusively an idea in the minds of a small percentage of people—mainly those in the health professions and a few public leaders. Prevention has little of the motivating reality of pain. It is based upon forethought, and forethought is the product of a mature personality. In the past preventive action has been the work of a few leaders *on behalf of others*. In contrast, the prevention of chronic disease requires the voluntary cooperation of every individual who is to benefit. It is in this area of health education that nurses have a large stake and a great contribution to make. Through interpreting scientific facts so that they have meaning to John and Mary, to Mr. and Mrs. Doe, through furthering community planning for the developing of resources for the use of all, the public health nurse helps to make prevention a personal responsibility and experience for the families she serves.

Twelve major chronic diseases were selected for analysis at the conference: malignant neoplasms, cardiovascular diseases, arthritis and rheumatism, poliomyelitis, multiple sclerosis, cerebral palsy, epilepsy, diabetes, blindness, deafness, tuberculosis, and syphilis. Summaries of scientific data about these diseases were prepared by groups of outstanding specialists. Each summary gave information about the causes of the disease, extent to which causative factors are controllable, measures useful in primary prevention, and possible areas for further research.

At the close of his paper Dr. Seegal said: "In my student days medicine had very little to offer the patient with severe diabetes melli-

(Continued on page 357)

International Health

Expert Committee on Nursing

Report of the first session

AS A SUMMARY of the Report on the First Session of the Expert Committee on Nursing of the World Health Organization has already been made in this magazine[1] and commented on in the *American Journal of Nursing*,[2,3] these particular comments will be confined to the significance of this report for European nurses as the writer has heard it discussed by a number of their leaders.

As indicated in the terms of reference: (1) to advise the World Health Assembly on measures to ensure the recruitment of nurses in proportion to the needs of each country; (2) to advise the World Health Assembly on measures to give nurses training in keeping with the numerous and complicated tasks which will devolve upon them; the questions the committee was asked to discuss and advise on in this first session are as old as the profession of nursing itself. Moreover, they are questions to which there can never be final answers as they must be repeatedly asked in relation to a constantly changing world society.

The committee membership was composed of individuals with special knowledge, through intimate experience, concerning one or several phases of the questions posed in the terms of reference. These individuals were brought together from diverse geographical areas for the purpose of considering these questions from a global point of view and pooling their thinking in order to bring forth a report which would have some relevancy, applicability, and practicability for each of the seventy-four member nations of the World Health Organization.

As the above-mentioned European nursing leaders express it, the chief value of the resultant report for them is not in its novelty but in its "moral support" through its reiteration and reemphasis of principles long familiar and accepted by the nursing educator and administrator but not so familiar to the lay groups on whose understanding and support the nursing profession is so dependent for its progressive development. This report, coming from a group of nurses representing various areas of the world, strengthens the local groups in their job of education and interpretation of nursing concepts, both within and without the profession.

The stress laid throughout the entire report on the need for research in all fields of nursing activities receives general acclaim. The recommendation that each government be urged to undertake or continue to study its own nursing resources, needs, and effective use

This discussion of the report was prepared for this magazine by Elizabeth W. Brackett, R.N. Miss Brackett is nursing adviser, Paris Office, International Health Division, the Rockefeller Foundation.

Expert Committee on Nursing. Report on the First Session. World Health Organization Technical Report Series. No. 24. Columbia University Press, New York, 1950. 30 p. 20c.

of personnel, presents a special appeal. This is so because there is an ever-growing awareness on the part of the nurses of the need in the European countries for research into the work of the entire nursing team, including such categories as medical-social and auxiliary workers. Functions should be analyzed, types of personnel indicated to carry out these functions, ratios and training required to prepare the different categories of workers should be determined. And it is recognized that such research, to be effective, must be carried on within the country itself, as each country presents different problems depending on its stage of development.

Studies along some of these lines have already been carried out in a number of European countries and many more are contemplated. It is being increasingly recognized, however, that the "committee method"* frequently employed in the past leaves something to be desired in that too often committee conclusions are based on opinion rather than on scientific investigation.

IN THE OPINION of the nurses, if these studies are to be effective, they must employ the services—advisory or administrative—of personnel trained in research methods. Therefore, the view expressed in the report of the Expert Committee that "WHO should provide professional and technical consultation services to national governments in planning and carrying out studies of this nature" is welcomed because it suggests a solution to the problem until such time as the nursing profession in the various countries can train some of its own group in research technics. The European nurses accept the view that they should provide leadership from their own profession in research studies dealing with their own problems.

Around the topic of the place and training of the auxiliary nursing group one finds a good deal of discussion and differing attitudes among the European nurses. Those responsible for nursing education in at least one European country—even though that country is experiencing a shortage of professional nurses—hope to avoid the necessity of producing two categories of nursing personnel, which they consider undemocratic. In other countries where the secondary group is well established, even though often without training, (in some instances it predates the professional group) the professional nurse leaders see a threat to the quality of nursing service unless much greater care is taken, than seems likely to be by their respective governments, to protect the situation by adequate legislation.

Fuller discussion of this whole subject and of legislation, not only as it pertains to the auxiliary nursing group but to all fields of nursing, would be welcomed in future reports.

In those European countries where the financing of nursing education falls in a no man's land between private and public support, without acceptance or recognition of individual responsibility by either, continued support of nursing schools is becoming progressively acute, as presentday students can no longer bear the major part of costs to the same extent as students of bygone years. Therefore, careful consideration of this tremendously important factor, basic to all nursing questions, is hoped for in subsequent meetings of the Expert Committee.

One nursing educator regrets the omission, under the discussion of basic nursing education, of recommendations regarding independent schools of nursing, with separate budgets for those schools conducted by hospitals.

It can be confidently expected that this whole subject of financing of nursing education will receive careful and detailed consideration in subsequent meetings of the Expert Committee when terms of reference will be delimited to specific areas of discussion.

It is of interest to mention that during the year following this first meeting of the Expert Committee on Nursing in Geneva, from February 20 to February 26, 1950, the Secretariat of the World Health Organization has found it possible to act on several of the committee's recommendations. Some important first steps

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* There are of course notable exceptions to this characterization of the committee method.

New Books
And Other Publications

FLORENCE NIGHTINGALE

Cecil Woodham-Smith. New York, McGraw-Hill Book Company, 1951. 382 p. $4.50.

The Florence Nightingale portrayed by Cecil Woodham-Smith bears little resemblance to Longfellow's gentle Santa Filomena. She also differs from the heartless tyrant pictured by Lytton Strachey. The book bears the same stamp of authenticity that marks Sir Edward Cook's *The Life* but is far more readable.

In beautifully chosen compelling words this new delineation of Miss Nightingale unfolds. Drawing upon intimate family correspondence, never before made available, her picture is presented with all her annoying characteristics and powerful drives fully exposed.

Florence Nightingale believed that she should be exempted from the stupid conventions and trivial amenities required of others because in 1837 God had called her to dedicate herself to His work. For over sixteen years in the face of her family's dismay and opposition she sought for a means by which she might answer her "call." The Crimean incident furnished the means. As a result of Miss Nightingale's achievements during those two years, two current concepts were forever destroyed—that of the British soldier as a drunken inhuman brute and that of the nurse as a drunken immoral drudge. Before she left the Crimea she dedicated her life to those whom she felt had been murdered by apathy, ignorance, and lack of care.

Once again because of the imperious needs of the British soldier she exempted herself from all demands made upon her associates. She alone sensed the urgency of her mission. Her health, her family and friends, and governmental policies were sacrificed to the Great Cause. Disappointments and delays, frustration and anger filled her days and years. Unable to find satisfaction in what had been accomplished because so much more lay ahead to be done, she drove herself and her coworkers with a relentless uncompromising frenzy. Rarely was she happy. She never felt rewarded for her superhuman labors nor did she feel that they were appreciated.

For over twenty years this invalid lady was the powerful moving force behind reforms in army medical organization, the War Office itself, and all matters concerning the welfare of the British soldier at home and abroad. Workhouse and nursing reforms were almost by-products of her service in behalf of her "children."

Calmness of spirit and the warm relations with others which she sorely craved finally came with old age. These at last brought a sense of fulfilment and serenity to Florence Nightingale, who was undoubtedly the most remarkable and productive woman of the nineteenth century.

—Mildred E. Newton, R.N., *Assistant Dean, University of California School of Nursing, San Francisco.*

THE ORGANDY CUPCAKES

Mary Stolz. New York, Harper & Brothers, 1951. 213 p. $2.50.

The Organdy Cupcakes is a second novel by a new young author who writes for teen-age girls. The humor and understanding which she brings to the undergraduate nurse's life are very refreshing.

The novel tells of three students in a hospital school of nursing in a large city. It explains why each girl entered the school—typical examples of the motives behind selecting a career—tells of the student's adjustment to school life and living in general, and her ambitions for the future. Although the book deals chiefly with the three students during their senior year it tells much about the preparation of nurses, the environment in which they learn the principles and practices connected with their chosen profession, and the fields in which they may specialize. Inter-

woven are descriptions of patients, their needs and care, of interns and of the social and recreational activities of the students. The action moves along at an absorbing rate which will have appeal to young readers.

The total situation in which the action takes place is not ideal, but no situation ever is. Although some professional nurses may feel that the descriptions of some of the faculty in the school of nursing are not typical or "come-hitherish," the writer believes that the book has so much charm, romance, and pleasant, challenging realism that it will attract young women to the profession. It will certainly fascinate the teen-ager who is trying to select a career. Those who are sincerely drawn toward nursing will find that *The Organdy Cupcakes* will help them to make up their minds to enter that profession!

—MARGARET REID, R.N., *Educational Director, Nursing Bureau, Health and Welfare Division, Metropolitan Life Insurance Company.*

GERIATRIC NURSING

Kathleen Newton. St. Louis, C. V. Mosby Company, 1950. 420 p. $4.50.

This book fills an important gap in the field of nursing since all nurses, whether working in hospitals or public health agencies, are keenly aware of the multitude of nursing problems inherent in caring for our aging population. Consideration of the total personality of the patient is given emphasis throughout the book. However, it is probably in the author's purpose, given in the preface, that the greatest innovation appears, for Miss Newton states that this book is planned for all who nurse the aged, "—it matters not whether in the home or in the hospital, in the private or the public agency—and is also for the student nurse or graduate nurse." This is truly an integrated point of view.

Teachers in both basic and advanced nursing programs will find this a very useful textbook, since up to the present time it has been necessary to use many books and magazine articles to get the essential detail required for this field of nursing care. Now material which concerns the health and welfare of our aging population is between the covers of one book. The bibliographies which are found at the end of each chapter are up to date and interesting from the point of view of the variety of sources covered.

The book is divided into three sections. The first includes such information as the number of people in our aging population, trends for the future, the place of the older person in our culture and society, problems of unemployment, rehabilitation, and economic resources which include the problem of medical care. Housing and recreation are also included in this introductory section, which is intended "to give the nurse a background of understanding of the aged, without which intelligent and sympathetic care is impossible."

The second section is concerned with the general hygiene and nutrition of this particular group of patients. A wealth of specific detail is included and the method of presentation is both useful and interesting.

The third unit is the main body of the book and can well be called a sourcebook of nursing care. One chapter is concerned with special treatments and is divided into three parts, one of which deals with medications; another with physical medicine including heat, massage, hydrotherapy, and therapeutic exercise; and the third with occupational therapy. There are chapters on anesthesia and postoperative care, nursing in diseases of the gastrointestinal tract, cardiovascular renal disease, diseases of the ear, nose, and throat, of the chest and of the skin, diabetes, neurological and psychiatric nursing, orthopedic, urologic, and gynecologic nursing.

From the above description of contents it is easy to see that this is an exhaustive treatise on the nursing care of an aging population. Much of the material covered has application to patients of all ages, and describes good nursing care. Therefore it is recommended for all nurses, who teach the prevention of illness and help patients to live within the limitations imposed by chronic disease.

—LILLIAN B. PATTERSON, R.N., *Dean, School of Nursing, University of Washington.*

A MANUAL OF CEREBRAL PALSY EQUIPMENT

National Society for Crippled Children and Adults, Inc., 11 South La Salle Street, Chicago 3. 1950. $3.75.

The 127 items illustrated in this manual were selected from those used in treatment centers throughout the country. A photograph or line drawing shows each piece of equipment in use and there are clear instructions with specifications for construction. There is an explanatory description of each piece of equipment and the possible modifications that will make it applicable for children with particular needs.

Some of the equipment can be used only in treatment centers, but a large majority can be used at home also, such as toys, dressing aids, adapted spoons, chairs, tables, various stabilizing and relaxation devices.

This book should be found in every public health nursing agency library, as it is a valuable reference that will assist the nurse in understanding the purpose and use of the equipment in relation to self-care education. Many of the suggestions will also help nurses to adapt equipment to the needs of patients with disabilities other than cerebral palsy.

—Jane R. Sloan, R.N., *formerly* NOPHN *Consultant, Joint Orthopedic Nursing Advisory Service.*

HAVING A BABY

Alan F. Guttmacher. New York, The New American Library of World Literature, Inc., 1950. 191 p. 25c.

Dr. Guttmacher has presented the story of human birth in a vitally interesting fashion in this book. He has traced the "folklore, the history, and the scientific facts" of pregnancy and birth. The presentation of the folklore with the scientific facts helps to relieve fears most commonly associated with pregnancy. The history, exciting as it is, might be a bit lengthy and confusing to some parents. The complete story of human birth is covered in the book and there is a fine continuity of subject matter from conception to the newborn child.

Although scientific terms and studies are included in this practical guide for expectant parents they are explained in such a way as to be easily understood by the average layman. Thus the author has foreseen the value of scientific facts in relieving anxieties of prospective mothers and fathers. Dr. Guttmacher has devoted several chapters to the abnormalities of pregnancy and labor—he himself admits that perhaps undue space has been given to this phase—but along with it he has adequately dealt with the normal. In view of the fact that parents today are discussing the subjects of childbirth without fear and rooming-in I think he could have omitted some of the complications and elaborated on these modern trends.

This guide book is now available in a paperbound 25c edition and can serve as a companion to Benjamin Spock's *Baby and Child Care* in answering many questions of prospective parents.

It will be a source of "comfort and inspiration" to prospective parents. To nurses it will provide a reliable basis of information about human birth on which to build the proper philosophy for instructing prospective parents.

—Elizabeth Peck, R.N., *Assistant Professor, Maternity Nursing, Syracuse University School of Nursing, Syracuse, New York.*

THE PHYSICIAN EXAMINES THE BIBLE

C. Raimer Smith. Philosophical Library, 15 East 40 Street, New York City. 1950. 394 p. $4.25.

This interesting book reveals the comprehensive coverage of medical things in the Bible and the apocryphal writings. The author has a happy knack of using Bible references to introduce discussion of and counsel on preventive measures, child guidance, sex relations, disease conditions, and other topics.

The pharmacological and toxicological effects of alcohol are described, and various Bible terms for drink analyzed. Statistics quoted emphasize the unfortunate effects of its injudicious use.

Under the heading Can Faith Cure Disease functional and organic disorders are contrasted. The therapeutic efficacy of faith in emotional problems is granted, although the effectiveness of faith in organic disease is questioned.

In examining the New Testament the author bases his proof of Christ's existence and resurrection on the transformed lives of His disciples. The operation of divine power in the miracles of Christ and His disciples is acknowledged, although Old Testament miracles are explained by natural means. The diseases in the New Testament are well discussed. Demon possession is placed on a natural rather than a supernatural level. The psychological heights of Christ's teaching are emphasized.

The section on the Scriptures in the atomic age is a summary of the evolutionary theory which the author establishes to his satisfaction. The Bible account of creation is then interpreted to harmonize with the evolutionary hypothesis.

The Bible reveals that God's purpose for man is eternal life, simply attained by the injunction, "Fear God, and keep his commandments: for this is the whole duty of man." An excellent concordance of medical terms used in the Scriptures is found at the end of the book.

The reviewer feels that the lack of spiritual applications, the lengthy discussion of evolution, and the emphasis of a changing Scriptural interpretation based on presentday concepts of natural law are points of weakness. However, the book is well written in a simple and readable style. A vast amount of information on medical subjects is brought together in concise form and is of scientific and educational interest.

—M. G. Hardinge, M.D., *College of Medical Evangelists, Loma Linda, California.*

SOCIAL WORK

Social Welfare Forum, 1950. Proceedings of National Conference of Social Work. New York, Columbia University Press. 1950. 344 p. $4.75.

Social Work in the Current Scene, 1950. Selected papers given at the National Conference of Social Work. New York, Columbia University Press. 1950. 384 p. $4.75. The thirty-four papers in this volume are arranged under the headings Program and Practice. They were chosen for timeliness, pertinence, and significance for today's needs.

NURSING

Illustrations of Bandaging and First-Aid. Compiled by Lois Oakes. Baltimore, Williams and Wilkins Company. Fourth edition, 1950. 308 p. $2.

Psychology for Nurses. Bess V. Cunningham. New York, Appleton-Century-Crofts. Second edition, 1951. 382 p. $3.50.

Nursing Service in a General Hospital. Factors in an Annual Report. Sister Mary Aloisiana Surma. Washington, D. C., Catholic University of America Press. 1951. 32 p. $1.

HEALTH EDUCATION

Pain that is Good for You. John Hancock Mutual Life Insurance Company. Write for free copy of pamphlet. A combination of two former booklets on causes and commonsense treatment of headache and stomach ache.

Your Blood Pressure and Your Arteries. Alexander L. Crosby. Pamphlet 168, Public Affairs Committee, 22 East 38 Street, New York 16. 31 p. 20c. Gives sound advice to those who have symptoms of high blood pressure on what to do and what not to do; also indicates precautions to be used to alleviate modern tensions which lead to the symptoms.

MENTAL HEALTH

Training in Clinical Psychology. Report of Conference on Graduate Education in Clinical Psychology sponsored by American Psychological Association under grant from National Institute of Mental Health. Victor C. Raimy, editor. New York, Prentice-Hall. 1950. 253 p. $4.

ORTHOPEDIC NURSING

Leg Amputee—Pre-Prosthetic Training. Signe Brunnstrom and Donald Kerr. Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, New Jersey. 1950. 44 p. $1. Contains directions about the care of leg amputee from amputation to mobilization. The directions include positioning, flap traction, bed exercises, bandaging, preparation for crutch walking, strengthening of remaining leg, stump care, and conditioning exercises. The description of each activity is short but clear and is accompanied by an illustration. This kind of preparation should make walking with prosthesis much easier.

FROM NOPHN HEADQUARTERS

A RESOLUTION

During the NOPHN regional conference in Omaha in April a group of administrators and board members of public health nursing services prepared the following recommendation and asked that it be sent to the U. S. Children's Bureau:

Resolved, That provision for public health nursing service be included in any special program for the care of the wives and children of men in the Armed Services and that there be provision made for payment to local health agencies supplying such care.

A copy of this recommendation and a letter requesting that there be nursing representation on any advisory committee to a program for the care of servicemen's wives and children have been referred to the Children's Bureau.

AN SOPHN IN ACTION

The Maryland State Organization for Public Health Nursing published three issues of the SOPHN *News* in 1950. This eight-page publication has proved a successful means for keeping members informed about current events and especially about trends in public health nursing. Each nurse is encouraged to be a reporter. Everyone attending meetings, institutes, et cetera, is asked to share information with her fellow workers through the *News*. Counties submit items about public health activities and this helps to create a spirit of unity among the nurses in the state.

The Education Committee of the SOPHN arranged for an off-campus course in maternal and child health through the Catholic University of America.

The joint boards of the SOPHN, MSNA, and MLNE, working through a special committee, sent a request to the Governor asking that the State Planning Committee finance a study of nursing resources in the state. This was approved and a Committee on the Survey of Nursing Needs has been set up. The study will shortly be under way. The three organizations sponsored a three-day annual meeting in November 1950. Anna Fillmore spoke at the luncheon meeting and Hazel Corbin of the Maternity Center Association in New York presented a paper on human relationships in family living.

The SOPHN has representation on many joint committees, especially the committees for the improvement of nursing service, for nursing resources to meet civil and military nursing needs, et cetera.

The public health nurses in Maryland enjoy their SOPHN and there is no question that their SOPHN serves them well.

GENERAL MEMBERSHIP CHAIRMAN

Powell Portrait

MANY READERS will remember Mrs. C. Wells Belin as the author of "How Dear to My Heart," which appeared in the magazine about a year ago. Written in Mrs. Belin's inimitable style, the article was an enthusiastic story of her views on NOPHN membership from the standpoint of the individual member and of the member of a board of directors of a public health nursing agency affiliated with the national organization.

Now Mrs. Belin is turning her enthusiasm for NOPHN to fine account. As NOPHN General Membership Chairman she has enlisted some seventy local board members as helpers in the drive for more 1951 general members. These special representatives are taking charge of enrolling fellow board members in the NOPHN, giving talks, distributing leaflets and generally stirring up interest in

NOPHN and its activities. Getting good results, too, as most recent reports indicate that a substantial increase in general membership will be achieved this year.

Mrs. Belin is a member of the Boards of Directors of the NOPHN and of the Visiting Nurse Association of Scranton and Lackawanna County. Her home is in Waverly, Pennsylvania.

To her and to all her helpers—a warm salute for the fine work they are doing.

REPRINTS AVAILABLE

The following reprints of recent articles in the field of education published in this magazine are now available: "Priorities in Public Health Nursing Education", "Completion of an Educational Program in Nursing Approved for Public Health Nursing", "Educational Programs for the Preparation of Public Health Nurses", and "Recommended Qualifications for Public Health Nursing Faculty and Teaching Personnel."

One copy of each may be secured free by NOPHN *members.*

UNITED DEFENSE FUND AND UCDS

"The United Defense Fund is heartening evidence that while we as a nation are mobilizing our resources of men, money, and goods to defend democracy, we are not neglecting to fortify the inner defenses of the human heart and spirit." With these words the President of the United States acknowledged the new organization's place in American society today.

Since the beginning of the year when the UDF was incorporated the participating organizations, including the NOPHN, have worked closely to achieve the basic purpose of the Fund. This purpose is joint package financing and joint planning through local community fund drives and local planning councils for health and welfare programs connected with defense. The services to be operated through defense funds are planned for two categories: services to the Armed Forces and services to civilians in communities congested because of the national emergency situation. The USO has been reactivated to serve the forces and the United Community Defense Services (UCDS) incorporated for hometown programs.

The agencies associated with UCDS will work in the mushrooming communities which grow up around military and industrial centers in time of emergencies—communities with greatly expanded needs in the health and welfare areas. The NOPHN expects to add another field worker to its staff shortly to meet requests for service in connection with the UCDS project.

NOPHN FIELD SCHEDULE—MAY

Anna Fillmore	Portland, Oreg.* New Orleans, La.*
Marjorie L. Adams	Columbia, S. C. Greenville, S. C.
Hedwig Cohen	New Orleans, La.*
Helen V. Connors	Seattle, Wash. Portland, Oreg.* San Francisco, Calif.
M. Olwen Davies	Boston, Mass.
Ruth Fisher	Portland, Oreg.*
Dorothy Rusby	New York City
Helen Snow	San Francisco, Calif. Oakland, Calif. Portland, Oreg.* Seattle, Wash. Tacoma, Wash. Spokane, Wash.
Jean South	Jersey City, N. J. Cincinnati, Ohio New Orleans, La.*
Elizabeth C. Stobo	New Orleans, La.* Houston, Tex.
Judith E. Wallin	Tulsa, Okla. Oklahoma City, Okla. Fort Smith, Ark.

* NOPHN Regional Conferences.

April field trips not previously reported: M. Olwen Davies, Chicago, Ill.; Biloxi, Miss.; Louise M. Suchomel, Somerville, N. J.

ABOUT PEOPLE YOU KNOW

Alda Paulette Haley has been appointed assistant supervisor at the Mott Haven Center of the Visiting Nurse Service of New York. Miss Haley came to the VNA following four years of nursing service with the United States Navy. . . . *Dr. Will H. Aufranc* has recently been appointed acting director, Health Resources Office, National Security

Resources Board, replacing Dr. Norvin C. Kiefer. (see April issue) Dr. Aufranc is on loan from the United States Public Health Service and prior to that had fifteen years of administrative experience in the public health field. . . . *Alice Rorrison Fisher* is now associated with the Seattle University School of Nursing as public health coordinator. Mrs. Fisher teaches and also works with the faculty on social and health aspects in nursing. . . . *Lucille Becker* is the new director of the Department of Public Health Nursing at St. Louis University. She was formerly nursing consultant with the Missouri State Crippled Children's Service. . . . *Leora V. Wohlleb* has joined the faculty of the University of Pennsylvania School of Nursing as lecturer. Previously she had been with the Fife-Hammill Health Center. . . . *Elaine Goben*, formerly educational consultant for the Colorado State Board of Nurse Examiners, has accepted the position of generalized nursing consultant for the Idaho Department of Public Health.

Clarissa Gibson, executive director of the VNA of Scranton and Lackawanna County since 1935, is the new director of the IVNS in Washington, D. C. That Miss Gibson's services are valued by the people of her community is attested to not only by the splendid tributes paid her by her staff and board members but also by the fact that one of the local newspapers printed an editorial in her honor. Miss Gibson is succeeded by Elizabeth Decker, who has been mental health nursing consultant with the Scranton VNA since May 1950. Earlier she was a supervisor in that agency. . . . The retiring director of the Washington IVNS is *Gertrude H. Bowling*. She will be greatly missed after her long years of service in the nation's capital. Miss Bowling has always been an ardent participant in local health and welfare activities. The IVNS, under her direction, has contributed generously to the promotion of nursing education through its field facilities for public health nursing students.

Four public health nurses in the group which participated in the Public Health Service-Economic Cooperation Administration course for overseas health workers have left for southeast Asia. *Mary Bouser*, *Walborg Wayne*, and *Florence Ullman* will work on health teams in Burma. In a generalized public health nursing program they will give special emphasis to maternal and child health services and health teaching. . . . *Lillian A. Gardiner*, recently public health nursing consultant for the USPHS in the regional office in Boston and earlier with the Territorial Health Department in Alaska, has gone to Bangkok with the ECA mission in Thailand. *Alice Marcella Fay* of the PHS has been detailed to Boston as regional public health nursing consultant, succeeding Miss Gardiner.

Expert Committee on Nursing

(Continued from page 346)

have been taken to implement some of the research projects recommended. A technical expert has been sent to at least one European country to advise on the setting up and carrying out of nursing studies. In response to the recommendation that WHO sponsor international seminars on nursing problems a two-week working conference, attended by public health nursing representatives from ten European countries, was held in Leyden, Holland, in October 1950, at which time the integration of nutrition, mental health, and health education in the educational activities of public health nursing personnel was discussed. Suggestions coming out of this conference for further working conferences on supervision and staff education will probably be acted upon in the foreseeable future.

REFERENCES

[1] Expert Committee on Nursing. PUBLIC HEALTH NURSING, August 1950, v. 42, p. 469-470.

[2] Petry, Lucile. Nursing on the world health front. *American Journal of Nursing*, October 1950, v. 50, p. 611-614.

[3] Patterson, Lillian B. The third world health assembly. *American Journal of Nursing*, December 1950, v. 50, p. 760-763.

NEWS AND VIEWS

BRIEFING FOR FOREIGN SERVICE

Nine public health nurses and nurse educators are among the U. S. Public Health Service specialists enrolled in a three-month orientation course for overseas workers being conducted under the joint sponsorship of the Economic Cooperation Administration and the USPHS. The nurses who have come from various parts of the country are: Mary Bouser, Florence Ullman, Walborg Wayne, Mabel Mortvedt, Mary Yardley, Grace Donovan, Dorothy Erickson, Helen Roberts, and Mabel Emge.

The specialists, slated for assignments in Burma, Thailand, Indonesia, and Indo-China, will be oriented to the customs and cultures of these countries. The course will include study at the Harvard School of Public Health and the USPHS Communicable Disease Center at Atlanta, Georgia.

At the Foreign Service Institute of the Department of State ten technicians, who will join Point Four missions in Liberia, Iran, Lebanon, Chile, Peru, and Mexico, are completing an orientation course in the languages and cultures of the countries they will serve.

One member of the group is Dr. Emil E. Palmquist, for the past several years director of public health for Seattle and King County, Washington. He is going to Iran as deputy director of the Village Improvement Point Four Program and director of its health activities.

Dorothy Grace Young, recently a public health nurse in the District of Columbia, is going to Liberia, where she will be attached to the Health Mission.

Since the above was prepared word has been received that Lillian A. Gardiner will be chief nurse adviser for the ECA mission in Thailand with headquarters in Bangkok. She will serve in an advisory capacity to the Ministry of Health in developing nursing in Thailand.

JANE TUTTLE MEMORIAL

A memorial has been established by the Board of the Instructive District Nursing Association of Columbus, Ohio, in commemoration of the many years of devoted, faithful, and creative service rendered to the people of Columbus by the late Jane L. Tuttle. She was executive director of the nursing service for nearly forty years.

Miss Tuttle was deeply interested in the problem of public health nursing education. Through contributions made by friends of the organization she started a fund for this purpose. This has now been designated as the Jane L. Tuttle Memorial Fund and as it grows is to be used for loans to nurses who wish to take advanced work in the field of public health nursing.

The fund is to be under the administration of the Board of the IDNA, but loans will be available to members of the joint staff of the IDNA and the City Division of Nursing.

Friends of Miss Tuttle and others who are interested may write to Louise McCune, IDNA, City Hall, Columbus 15, Ohio.

BCG

The American Trudeau Society of the National Tuberculosis Association has approved the use of BCG vaccine for nurses and physicians because they are constantly exposed to tuberculous infection. The BCG vaccine has also been approved for (1) Indians (2) inmates and attendants in mental institutions and (3) slum areas where proper living conditions have not yet been achieved. For the same reason it has been justified as a temporary expedient in some countries where the tuberculosis death rate is high and facilities for isolation and treatment are almost nonexistent. The approval of the Trudeau Society for the use of BCG under these conditions was given with the full knowledge that only slight protection would be achieved and

in no sense as a substitute for an adequate program of casefinding, isolation, and treatment.

CHRONIC ILLNESS STUDY

A special study to find out how many people are chronically ill in the United States is shortly to be undertaken by the Hunterdon County Medical Center (New Jersey). The center has received a grant from the Commonwealth Fund for this activity. The study will be based on plans developed by the Commission on Chronic Illness and consultation will be given by the commission's staff.

A similar survey in an urban area is being planned by the commission. These studies should provide yardsticks so that individual communities can measure their own needs for hospital beds, home care programs, rehabilitation, and other community services for the care of the chronically ill.

WANTED: NURSING CONSULTANTS

The U. S. Civil Service Commission is still accepting applications for the position of nursing consultant under its Announcement No. 171 issued in May 1949. There is an urgent need for qualified people in these positions which are in the specialized fields of public health, maternity, orthopedics, pediatrics, and psychiatry. The salaries for nursing consultants range from $4,600 to $7,600 a year.

Headquarters of persons appointed to nursing consultant positions may be in Washington, D. C., or appointees may be assigned to duty in regional offices of federal agencies and, in some instances, in various communities throughout the country.

Interested persons may obtain further information and application forms at most first- and second-class post offices, from Civil Service regional offices, or by writing directly to the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted in the Commission's Washington office until further notice.

Public health nurses are also needed for some of the Indian Reservations in the west and in Alaska. There are a few openings for public health nurse midwives with beginning salaries of $4600. Although the age limit for the public health nurse positions is forty, nurse midwives up to sixty-two years of age will be considered.

PREVENTION OF BLINDNESS

At the annual conference of the National Society for the Prevention of Blindness, authorities in many fields presented their views and newest findings. Dr. Franklin M. Foote, executive director of the society, said that during the last war seven percent of the men examined by selective service boards were rejected because of faulty vision. Subnormal eyesight, he added, kept twenty-five to forty percent of defense workers below normal production. He urged that industry promote vision tests, wearing of safety equipment, and the proper use of illumination and color.

In his paper on retrolental fibroplasia, Dr. Algernon B. Reese, clinical professor of ophthalmology at the College of Physicians and Surgeons, Columbia University, stated that this was a disease affecting twenty-five percent of all premature infants with birth weight of two to three pounds. If the disease is not detected and treated within the first three months, blindness will surely follow. A cure for retrolental fibroplasia has so far not been found but it is presently being treated with ACTH.

ACTH and Cortisone are also being used in the treatment of sympathetic ophthalmia (loss of vision in one eye following serious injury to the other eye). Dr. John M. McLean, attending surgeon in charge of ophthalmology, New York Hospital-Cornell Medical Center, stated that both these drugs offer the first successful method of directly treating this eye condition. While the new drugs also give promise of widening the possibilities for successful corneal grafts, they have been found to have no value in treating cataracts and glaucoma. They cannot replace antibiotics in routing infection; they can only suppress inflammatory conditions.

Fortunately another drug, DFP (diisopropyl fluorophosphate) has been recently found effective in treating glaucoma. Dr. Irving H. Leopold of Philadelphia cited the discovery of DFP as an example of "how research work

which starts out along one line may lead to results that are useful along a completely different line." DFP is a derivative of certain chemicals which Germany had prepared for possible use as a war gas. Allied researchers found that DFP constricts the pupil of the eye for long periods of time and will lower intraocular pressure in eyes with glaucoma.

Safety methods were described by John L. Hopkins, superintendent of the Board of Education at Hastings, New York. When the wearing of safety goggles by students in metal and wood shops was made a requirement there was a complete drop in the number of eye accidents. In over a year and a half, the safety goggle program has reduced to zero the number of cases of eye injury.

DISTURBED CHILD STUDY

The New York School for Social Research has started a new course called "Casework in Authoritarian Settings." Taught by Hyman Grossbard, authority in the field of helping emotionally disturbed children, the course has as students, policemen, social workers and probation officers. It is aimed at providing those who work with "delinquent" children with a better understanding of the child's personal problems as they relate to his delinquency. Through class discussion of typical cases the students discover how best to help these children out of conflict to emotional growth and maturity.

MENTAL HEALTH STATISTICS

Surgeon General Leonard H. Scheele has announced the formation of a new reporting area for the compilation of mental health statistics. Eleven states—Arkansas, California, Illinois, Louisiana, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania and Virginia—in which there are 58 percent of the nation's population and 55 percent of all hospitalized mental patients, have agreed on the new reporting arrangement. Other states will be encouraged to join the venture which is expected to yield more adequate and uniform statistics on mental health patients. Emphasizing the need for more comprehensive statistics, Dr. Scheele said the new reporting system is a step toward greater understanding of the efficacy of various treatment methods for mental diseases.

CHILDREN'S BUREAU APPOINTMENTS

Appointments of Dr. Katherine Bain and Melvin H. Glasser as associate chiefs of the Children's Bureau have been announced by Federal Security Administrator Oscar R. Ewing. Formerly director of the bureau's Division of Research, Dr. Bain will serve as associate chief of program development in research and in administration of grants to states for child health and welfare.

Mr. Glasser, who was executive director of the Midcentury White House Conference on Children and Youth, will be associate chief for state and community relations to put objectives of the conference into action. He will also work with major national organizations on planning services for children and will be responsible for the international programs of the bureau.

SURVEY

An extensive health research project has recently been undertaken in Canada. Formerly there had been no effective measure of the volume of sickness, nor of the various types of illness in terms of time lost or of financial cost. The physician deals with fragments of the problem, but before preventive health measures can be applied, it is absolutely essential that the true pattern of sickness in the community be discernible. Adequate knowledge of the pattern of sickness will have a direct bearing on the populace in that it will allow for using money and medical resources to the greatest effect. The survey is being conducted across Canada on a sample basis with 40,000 of the population as the sample. Those families selected are visited once a month for a period of a year by public health nurses attached to local and metropolitan health units.

SWEETS

Probably one of the reasons the early settlers of Virginia decided to stay in this country was the great abundance of sweet potatoes. Noticing the Indians carefully cultivating their sweet potato crops, the

colonists thought it must be a good thing and soon made it a staple of their diet. Though its fame spread all over the world it still remains a staple in many American homes. Cheaper than many other vegetables, the sweet potato is rich in vitamin A and has good supplies of vitamins B and C. You can boil, bake, hash, or mash sweet potatoes and for an interesting recipe booklet write the U. S. Department of Agriculture, 139 Centre St., New York 13, N. Y.

● Indiana University at Bloomington, Indiana, is offering from June 21 to August 10 the following courses: Principles of Public Health Nursing; Public Health Organization; Advanced Principles of Public Health Nursing; Teaching in Nursing; Field Experience in Teaching in Public Health Nursing; Field Work in Public Health Nursing. From August 10 to 24 the University will conduct a School and Community Health Workshop. For further information write to Lucy C. Perry, assistant professor, Division of Nursing Education.

HOME SAFETY

The National Safety Council is now offering an annual Home Safety Service Membership. The dues are $5 a year. A subscriber becomes a member of the Council and receives many benefits including the "Home Safety Review", "Home Safety Program Service", "Accident Facts", and many other worthwhile services and publications. For further information, write to the Council, 425 N. Michigan Avenue, Chicago 11, Illinois.

TV AND HEALTH

Members of the New York County Medical Society have voted to start a series of television broadcasts to present authentic information in medical advances. The program will have a panel discussion format with a layman as moderator to ask questions of the "expert." The program will consider one general topic each week such as cancer, arthritis, or ulcers, and present the information in layman's terms.

National Conference on Chronic Illness

(Continued from page 344)

tus, pernicious anemia, congenital heart disease, Addison's disease, rheumatoid arthritis, or cirrhosis of the liver, to name a few chronic illnesses. Today the situation is much different. With this fine record over the past forty years and the present pace of research, is it not possible that the medical student of 1975 or 2000 may add hypertension or arteriosclerosis or cancer or all three to the list of preventable or controllable chronic diseases?" Certainly there is inspiration in these thoughts —inspiration to do everything within our power as individuals and as nurses to further the conquest of this great destroyer of happiness—chronic illness.

There is another aspect of the subject especially urgent today and that is our increased need for personnel for national mobilization. One out of every six persons is affected by a chronic disease. It is our greatest drain upon manpower. Now, when so much is known about prevention and when so much has been accomplished—now is the time for an allout attack.

The Commission on Chronic Illness, formed originally by the AHA, AMA, APHA, and the APWA, sponsored this conference in cooperation with the National Health Council and the USPHS. Conferences on other aspects of chronic disease are being planned for the future. The papers and reports of the conference on prevention will be available at a later date in the conference *Proceedings*.

RUTH FISHER, R.N.
NOPHN *staff associate to the Commission on Chronic Illness.*

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THE VERY BEST:

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  100% Wool Elastique, Convertible Collar, Weather Proofed, Fully Lined Skinners "Sun Bak" Satin or Plain Satin Lining (for all year wear) in stock sizes **$62.50**

  Extra Zippered in Red Wool Lining with sleeves attached add $10.00

  Coat Custom Tailored, Add 10%

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  100% Wool Elastique, Convertible Collar, Weather Proofed, Skinners "Sun Bak" Satin in stock sizes **$62.50**

  Extra Zippered in Red Wool Lining add $10.00

  Coat Custom Tailored Add 10%
  When ordering, enclose $10.00 deposit. Advise shipping instructions.

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  In a deep Navy Blue Shade. Smart, Practical, Slenderizing. Tubbable—Pre Shrunk—no Ironing. Color Fast Non Puckering Seams. Short or long Sleeves **$14.95**

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- **GALEY-LORD (CRAMERTON) SEERSUCKER**

  Blue-White Stripe, Cool, Crisp, Smartly Styled. Short Sleeves—Sanforized—Color Fast. **$8.25**
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  Solid Navy Blue Dark Shade, Guaranteed Color Fast—Sanforized. **$8.25**
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  Sizes—Junior—11-13-15. Regular—10 to 42
  When ordering enclose $2.00 dep. Ship for balance C.O.D.

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And the cost is low. No waste or leftovers with Gerber's individual portions—lots of nourishment! Gerber's special way of processing retains—to a high degree—needed vitamins and minerals naturally present in food.

IT'S A GIFT, of course. New, enlarged edition of our "Special Diet" booklet offers recipes for Bland, Soft, Mechanically Soft and Liquid Diets. Also gentle hints on tray and table service. For your copies write to Dept. FN6-1, Fremont, Michigan.

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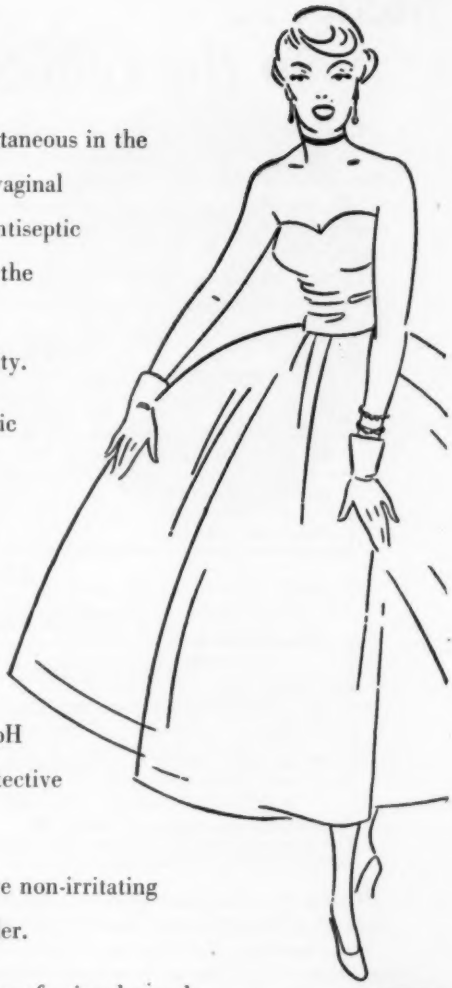
is seldom spontaneous in the woman distressed by one of the common vaginal infestations. For such a patient, Tyree's Antiseptic Powder has distinct value. By overcoming the offending pathology, it re-establishes the patient's normal enthusiasm and spontaneity.



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Meat . . .
in the Low-Sodium Diet

Clinical experience[1, 2] and investigative data[3] indicate that the liberal use of meat may not be contraindicated when sodium intake must be restricted. Because unsalted meat contains only relatively small amounts of sodium, while contributing importantly to other nutrient needs, meat deserves special consideration in very-low-sodium diets, in sodium-poor diets, and in no-extra-sodium diets.

Table I lists the amounts of sodium[3] in three kinds of meat. Table II gives the estimated amounts of sodium in hospital diets planned for cardiorenal vascular patients.[4]

SODIUM IN MEAT[3]

	Sodium Provided by 60 Gm. Serving	Sodium Provided by 100 Gm.
Beef, without bone	32 mg.	53 mg.
Lamb, without fat	66 mg.	110 mg.
Pork, without fat	35 mg.	58 mg.

Table I

SODIUM IN HOSPITAL DIETS[4]

Sodium-Poor Diets*				Very-Low-Sodium Diet†
40 Gm. Protein	70 Gm. Protein	100 Gm. Protein	130 Gm. Protein	70 Gm. Protein
400 mg. Na	500 mg. Na	800 mg. Na	1,000 mg. Na	200 mg. Na

Table II

*Foods prepared and served without salt.
†Weighed diet. May contain 4 oz. of unsalted meat.
(Normal diets contain approximately 4 Gm. of sodium daily.)

Hence, the data here shown indicate that relatively generous amounts of meat may be included in low-sodium diets.

Meat serves well in the therapeutic objective of maintaining a high state of nutrition in patients with congestive heart failure or nephritic edema by providing valuable amounts of biologically complete protein and of B complex vitamins, including the recently discovered B_{12}.

1. Wheeler, E. O.; Bridges, W. C., and White, P. D.: Diet Low in Salt (Sodium) in Congestive Heart Failure, J.A.M.A. 133:16 (Jan. 4) 1947.
2. Wohl, M. G., and Schneeberg, N. G.: Dietotherapy (Cardiovascular Disease), in Jolliffe, N.: Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, chap. 27.
3. Bills, C. E.; McDonald, T. C.; Niedermeier, W., and Schwartz, M. C.: Survey of the Sodium and Potassium Content of Foods and Waters by the Flame Photometer, Fed. Proc. 6:402 (Mar.) 1947.
4. Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 113.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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LIQUID PYRINATE

KILLS HEAD, CRAB, BODY LICE, AND THEIR EGGS... ON CONTACT

8,000 CLINICAL TESTS in the District of Columbia jail prove A-200 Pyrinate highly effective in killing both parasites and their eggs . . . on contact!

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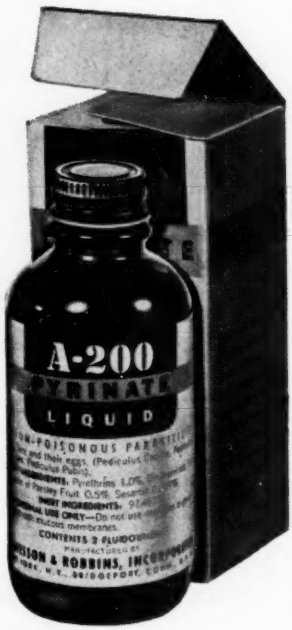

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POSITIONS AVAILABLE

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WANTED—The expanding National Blood Program of the American National Red Cross offers a different professional nursing specialty to nurses who can fill chief nurse and deputy nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in teaching, administration, and public relations. Blood bank or operating room experience is desirable but not required. Inquiries should be directed to Mr. Raymond R. Fisher, Administrator for Personnel Services, National Headquarters, American National Red Cross, Washington, D. C., and reference should be made to the National Blood Program.

WANTED—Public health nurses for generalized program in suburban area; staff education and students; 5-day week, vacation, sick leave, and retirement benefits. Write to Mr. John Davenport, Personnel Director, The Court House, Arlington County, Virginia.

WANTED—Public health nurses, New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,400; 37-hour week, liberal vacation and sick time allowance, pension rights, inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, New York.

WANTED—Public health nurses for county health departments in Oregon; salary $260 or more to start; established personnel policies; career opportunities. For detailed information write today to A. T. Johnson, Merit System Supervisor, 1019 S.W. Tenth, Portland 5, Oregon.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,652-$3,336; graduate nurses as assistant PHNs, $2,340-$2,772; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

WANTED—Director, generalized nursing program; population 78,000; 13-nurse staff, one supervisor; preparation required: bachelors degree, 5 years of public health nursing experience, at least 2 of which must have been under adequate supervision and 2 of which involved supervision of public health nurses; New York State retirement plan; 2 days vacation a month, 1 day sick leave a month; car furnished for professional use. Apply to Dr. H. C. Miles, Cattaraugus County Health Department, Olean, New York.

WANTED—Immediately, staff nurse; generalized public health nursing program established over a 10-year period; salary $250-297, depending upon qualifications and experience. Apply to Director Lawrence County Health Department, Lawrenceville, Illinios.

WANTED—Qualified experienced supervisor for challenging position in Northwest; retirement plan, social security, 5-day week, four weeks vacation; car optional; salary range $300-350, depending on qualifications. Write to Mary I. Breneman, Director, Visiting Nurse Association, 1008 S.W. 6th Avenue, Portland 4, Oregon.

WANTED—Qualified staff nurse; attractive new office; agency-owned cars; 5-day week; all NOPHN standards; salary based on qualifications and experience. Apply to Harrison Nursing Association, 216 Halstead Avenue, Harrison, New York.

WANTED—Qualified staff nurses for generalized program in large university town; 39-hour week; liberal vacation, sick-leave allowance, retirement benefits; inservice training; staff association; student program; salary range $2,940-$3,660, depending on qualifications and experience; depreciation and car allowance on own car. Write to Ann L. Schmich, Executive Director, Visiting Nurse Service, 418 West Mifflin Street, Madison 3, Wisconsin.

WANTED—Director of department of public health services; RN with BS degree, MA desirable; to direct a public health nursing service, an outpatient department with 20 clinics, and a department of physical medicine; at least 5 years supervisory and administrative experience required; liberal personnel policies, including 40-hour week, 4-week vacation, group hospitalization insurance, and sick leave; salary open. Apply to Personnel Office, Englewood Hospital, Englewood, New Jersey.

WANTED—Qualified nurse for generalized public health nursing program; starting salary $3,045; car furnished; 5-day week; good personnel policies. Write to Mr. Michael Reddy, Chairman, Sullivan County Public Health Committee, Callicoon, New York.

WANTED—Educational director, child welfare consultant, supervisor for 46-nurse staff, undergraduate student affiliation; combination agency; 40-hour week; degree majoring in public health, and experience required. For full information write to Ruanna S. Gordon, Director, The Visiting Nurse Association, 401 Municipal Building, Dayton 2, Ohio.

WANTED—Staff nurse. Public health training desirable; car furnished; 4-week vacation; good salary. Write to Plymouth Community Nurse Association, 10 Market Street, Plymouth, Massachusetts.

WANTED—Supervisory and staff nurse personnel; voluntary agency; 8-10 nurses and nutritionist; bedside nursing and health supervision program; 40-hour week, good personnel policies; National Retirement plan and social security; salary dependent on preparation, experience, and personality. Write to Nursing Director, Visiting Nurse Association of New Britain, Inc., New Britain, Connecticut.

WANTED—Staff nurse and substitute for nonofficial agency in attractive industrial community, population 83,000; generalized program; 10-nurse staff; salary based on preparation; excellent personnel policies, 5-day week, 4 weeks paid vacation, retirement plan and social security. Apply to Director, Visiting Nurse Association, 194 Concord Street, Manchester, New Hampshire.

WANTED—Director, public health nursing service, also educational director, combined city, county, and VNA program; industrial city, population 80,000, county population 200,000; southeastern state; excellent salaries for experienced well prepared candidates. Write to box 5651, PUBLIC HEALTH NURSING magazine.

WANTED—Directing supervisor, public health. Visiting nurse work, school health program; salary based on experience; 40-hour week; 30 days vacation with pay; sick leave; small staff; mileage for own car. Requirements: college degree, postgraduate work in public health; staff nurse experience. Write to Northern Bergen Nursing Service, Inc., Ramsey, New Jersey.

WANTED—Director, VNA, Muncie, Indiana; industrial city of 65,000, State Teachers College; NOPHN qualifications preferred; 5-nurse staff; student program; liberal personnel policies; car essential; salary open. Write to Mrs. Louis P. Fisher, RR2, Farmland, Indiana.

WANTED—Staff supervisor for visiting nurse organization; must meet NOPHN requirements; retirement plan; social security; 30 days vacation, 14 days sick leave; beginning salary dependent upon previous experience and training; semi-annual salary increases to maximum. Write to Director, Visiting Nurse Association, 316 Elizabeth Street, Utica, New York.

WANTED—Public health nurses and supervisor in tuberculosis, Baltimore County Health Department; population 270,000; suburban, industrialized, and rural areas; county seat 8 miles from Baltimore; generalized service including progressive school program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and special preparation in tuberculosis nursing required; beginning salary $4,000. Public health nurses: qualified, beginning salary $2,600-$2,700; junior nurse, beginning salary $2,400; trainee, beginning salary $2,300. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

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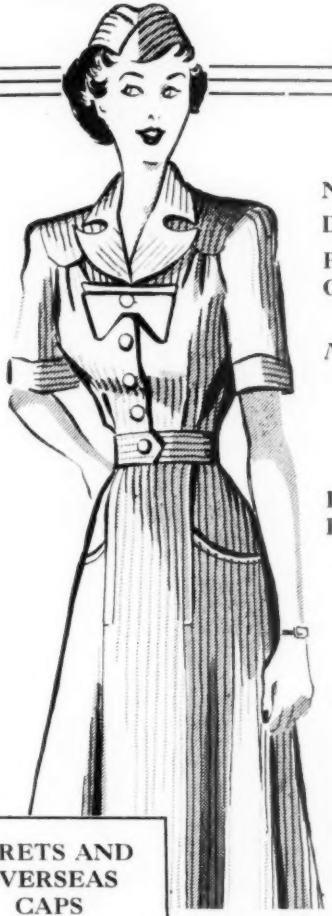

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